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TABLE OF CONTENTS

SECTION A – PROJECT GOALS AND BENCHMARKS ..... - 1 -

Introduction / Goals ..... - 1 -
Project Introduction ..... - 1 -
Demonstration Objectives ..... - 3 -

SECTION A.1 – CASE STUDY ..... - 10 -

Case Study for Nursing Facility Transition for a Person with a Physical Disability - 10 -
Case Study for the Transition of an Elder from a Nursing Facility ..... - 16 -
Case Study for Transitions from the Developmental Center or a Community Intermediate Care Facility for the Mentally Retarded (ICF/MR) ..... - 20 -

SECTION A.2 – BENCHMARKS ..... - 25 -

Benchmark #1: Projected number of eligible individuals to be assisted in transitioning - 25 -
Benchmark #2: Qualified expenditures for HCBS during each year of the demonstration program 26
Benchmark #3: Develop Behavior Crisis Intervention and Coordination 27
Benchmark #4: Develop and Implement Plans to Educate Consumers 29
Benchmark #5: North Dakota will implement a crisis response process to support: 34

SECTION B – DEMONSTRATION IMPLEMENTATION POLICIES AND PROCEDURES 37

B.1 Participant Recruitment and Enrollment 37
Target Populations 37
North Dakota Developmental Center and Community Based Intermediate Care Facilities for the Mentally Retarded Transition Recruitment and Enrollment Process: 48

B.2 Informed Consent and Guardianship 53
Procedures for Providing Informed Consent 53
Awareness of Transition Process/Knowledge of the Services and Supports 53
Information about Rights and Responsibilities 54
Waiver Appeal Process 55
Guardianship Alternatives 55
Guardian Relationships 55
MFP Participant Welfare 56
MFP Guardianship Requirements and Interactions 56

B.3 Outreach, Marketing and Education 58
MFP Brochure 58
Electronic Media 59
Newsletters 59
Outreach/Education 59
Pre-implementation Outreach /Marketing/ Education Activity 61

B.4 Stakeholder Involvement 62
Membership 63
Developmental Center – Transition to the Community Task Force 66
Other Stakeholder Involvement 66
Legislative Partnership Committee 66

Long Term Care Association 67
Home and Community Based Services 67
MFP Benchmark-Stakeholder Group 67
Prior Stakeholder Contributions: 68

B.5 Benefits and Services 69
Target Population 69
Institutions 69
Qualified Residences to Which Persons Will Be Transitioned 69
Money Follows the Person Demonstration Services for Persons with a Physical Disability or an Elder 69
Home and Community Based Services Waiver Services 70
Additional Services Available for the Elderly and Disabled paid for by other state funding sources 72
Money Follows the Person Demonstration Services for Persons with a Developmental Disability 74
Qualified Home and Community-Based Services Available to Individuals with a Developmental Disability through the Demonstration Program 74
Current Programs Serving Persons with a Developmental Disability 75

NEW Money Follows the Person Services 77
Home and Community Based (Demonstration Services / Supplemental Services for Persons Transitioning from a Nursing Facility) 77
24 Hour on Call Nursing Service (Demonstration Service for all Money Follows the Person Participants) 78
Supplemental Services (All Money Follows the Person Participants) 78
Application Process for Supplemental Services 79
Money Follows the Person Eligibility 79
Qualified Home and Community Based Services to be Paid at the Enhanced FMAP Match Rate 79
Money Follows the Person Demonstration (Waiver) Services Available by Money Follows the Person Population Group 82
Transition at Termination of Money Follows the Person Eligibility 83
Appeals 83
Closures, Denials, Terminations, and Reductions in Services Policy (HCBS Waiver or State Medicaid State Plan Services) 84
Access 87
Nursing Facility Transitions 87
Transition Coordinator Qualifications 88
Knowledge, Skills, and, Abilities Requirements 88
Transition Coordinator to Participant Ratio 88
Home and Community Based Services Case Management 89
Home and Community Based Services Case Manager Qualifications 89
Home and Community Based Services Case Manager to Participant Ratio 89
Developmental Center and Community ICF/MR Transitions 89
Developmental Center Social Worker 91
Additional Access 91
24-Hour Emergency Back-Up Supports 92
Adult and Child Protective Services 94
Division of Emergency Management 95
Emergency 911 Services 95
24 Hour Nurse Call Service Oversight 95
Access to Appeals and Protective Services 96
75-01-03-03. Fair hearing - Who may receive. 96
Client Assistance Program 98
The Protection & Advocacy Project 98

Vulnerable Adult Protective Services 99
Seeking Services or Reporting Suspected Abuse or Neglect 99
Reporting Suspected Child Abuse or Neglect 100
Institutional Child Protection Services 100
Long Term Care Ombudsman Program 100
The Ombudsman Program Serves 101
Volunteer Community Ombudsmen 101

B.7 Self-Direction 102
Nursing Facility Transitions 102
Person Centered Planning 103
North Dakota Developmental Center and Community Based Intermediate Care Facilities for the Mentally Retarded Transitions 103
Person Centered Planning 104

B.8 Quality 108
North Dakota Home and Community Based Services Quality Assurance Overview 108
75-01-03-08.2. Notice of preadmission screening and resident review determinations 113
Service Plan 116
Qualified Providers 118
Critical Incidents Definitions 125
Attachments 132

B.9 Housing 134
Definition of qualified residences for MFP participants 134
Description of the State Regulations for Each Type of Housing 134
Document Requirements for all Residences into which Money Follows the Person Participants are Placed to Assure They Meet Money Follows the Person Statutory Definitions for “Qualified Residences” 136
Project Based Housing Resources 137
Tenant Based Housing Resources 138
Strategies to assure a sufficient supply of qualified residences and to assure Money Follows the Person participants have a choice among them. 138
Resources 141
Definitions 143

B. 10 Continuity of Care Post Demonstration 144
Nursing Facility Transitions 144
Home and Community Based Services Waiver Services available to persons with a physical disability or an elder after MFP discharge 144
Service Payments for the Elderly and Disabled (SPED) 145
Expanded Services Payments for the Elderly and Disabled (Ex-SPED) 145
Older Americans Act Services 145
Services for Persons with a Developmental Disability 146

SECTION C – Organization and Administration 148

C.1 Organizational Structure 148
ND Department of Human Services Organizational Chart 151
Division of Medical Services Organizational Chart 152

C. 2 Staffing Plan 153

C. 3 Billing and Reimbursement 155

Medicaid Fraud and Abuse Unit Condensed Manual and Policies as they Relate to MFP Participants 155

SECTION D – EVALUATION..... 157

SECTION E – Final Project Budget 158

Budget Narrative 158

APPENDIXES

Appendix B.1 Participant Recruitment and Enrollment
- B.1-A: Money Follows the Person Referral
- B.1-B: Money Follows the Person Role Matrix
- B.1-C: Money Follows the Person Fact Sheet
- B.1-D: Money Follows the Person Brochure
- B.1-E: Education PowerPoint/Person Centered Planning Information
- B.1.F: Referral Packet Information List

Appendix B.2 Informed Consent and Guardianship
- B.2-A: Informed Consent Document
- B.2-B: Money Follows the Person Rights Document
- B.2-C: Guardianship Expectation Document

Appendix B.5 Benefits and Services
- B.5-A: Supplemental Services Request Form
- B.5-B Notice of Denial or Termination of Demonstration Services

Appendix B.8 Quality
- B.8-A: Transition Assessment
- B.8-B: Independent Living Plan which includes risk mitigation plan/24 hour backup
- B.8- C: Developmental Disabilities Individual Service Plan
- B.8-D: Developmental Disabilities Progress Assessment Review (PAR)
- B.8-E: Resident Decision Profile
- B. 8-F: Notification of Denial, Termination, or Reduction in Service Form
- B.8-H: Risk Mitigation Policy and NF and DD forms
- B.8- I: 24-backup Planning Policy and Back-up Plan
- B.8-J: Critical Incident Reporting and Management Policy
- B.8-K: Checklist for the Independent Living Plan
- B.8-L: Protection and Advocacy Reporting Guidelines
- B.8-M: DDD-006-Response to Reports of Alleged Incidents of Abuse, Neglect, or Exploitation of Individuals Receiving Developmental Disabilities Services from Licensed DD Providers

Appendix F: MFP Self-Direction Document

Appendix G: Grant Program Administrator Resume

Appendix I: ADRC Proposal

Appendix J: Transition to the Community Task Force

SECTION A – PROJECT GOALS AND BENCHMARKS

Introduction / Goals

Project Introduction

In 2007 the Centers for Medicare and Medicaid Services awarded North Dakota(ND) a grant through the Money Follows the Person (MFP) Rebalancing Demonstration Program established by the Deficit Reduction Act of 2005. The State intends to use MFP funding to develop processes that will assist individuals with moving out of Intermediate Care Facilities for the Mentally Retarded and Nursing Facilities (institutions) and to assure that the necessary Home and Community Based Services are available to support community living. The design and development of a system that can serve all individuals in need of support services in the community will be the benchmark of success for the North Dakota MFP grant process.

North Dakota will provide transition assistance to those persons that would not have naturally moved out of nursing facilities by offering a Nursing Facility Transition Coordination demonstration/supplemental service. ND has 83 nursing facilities with the capacity to serve 6,210 persons. The current total population of our nursing facilities is at 5,742 or about 94% occupancy. The State will continue to support the efforts of North Dakota nursing facilities as they discharge approximately 1,100 residents per year to their home or to an alternative level of care. One in three of all persons discharging from ND nursing facilities return to their own home and one in four transitions to a lower level of care.

A Nursing Facility Transition Coordination service will be developed to facilitate transitions from nursing facilities across the state. The four ND Centers for Independent Living will be contracted to provide these services. Supplemental services will be offered to pay for onetime transition costs to additionally support transitions from nursing facilities into community settings. A Nursing Call Service will be developed to offer 24 hour backup assistance to all participants of the grant.

To promote long term and sustainable system changes the Stakeholder Committee will identify and document barriers to services and unmet support needs. Services considered necessary will be identified and communicated to the appropriate State legislative and governmental agencies, advocacy groups, and provider groups. The Stakeholder group will advocate for the funding and/or policy changes required to “fill the gaps” in the service delivery system. The MFP Stakeholders Committee and workgroups will be tasked with the overarching responsibility of collaboration for system change to increase the capacity of the community support services.

An application for an $800,000 grant to fund the development of an Aging and Disabilities Resource Center will be submitted to the Centers for Medicare and Medicaid in July of 2008. The ND legislature authorized $40,000 in matching funds and the authority for the Department of Humans Services to establish an Aging and Disabilities Resource Center during the 2007 legislative session. The ADRC will be established in one pilot location in ND with a minimum county population of 45,000. It will serve as a single-point-of-entry for long term care and support services for adults with disabilities in the designated pilot region. The ADRC will also provide a Web-based (and telephone/TTY disability accessible) Aging and Disability Resource Center that can be accessed by seniors and adults with disabilities, their family members, providers, and others to obtain information and assistance accessing long term support services.

The MFP grant process also will be utilized to promote state wide education processes to increase public awareness and utilization of the Long Term Care services available in the community. Once developed, an Aging and Disabilities Resource Center (ADRC) will support this goal. Education will promote a better understanding of the support needs of persons with a disability and for persons that are aging, help to communicate the services currently available, and the most effective ways to access services. The ADRC will play a key role in this process.

The ADRC will support the efforts of the Centers for Independent Living in transitioning individuals from nursing facilities by referring potential consumers and providing information about the local resources available to support persons transitioning to the community. The ADRC will also assist consumers currently living in the community connect with resources and services that may assist them to delay admission to an institution.

For the past 20 years North Dakota has been working to ensure that persons with developmental disabilities are being cared for in the least restrictive environment possible. In the 1960s, the Developmental Center (Center) had over 1,200 residents between its two facilities in Grafton and Dunseith. The Dunseith facility has closed and the resident census at the Center has declined to the current level of about 124 people. This decrease was a direct result of the availability of improved training and treatment, increased community-based supports including the establishment of eight regional human service centers, and growth in the number of private providers.

North Dakota also has 54 community Intermediate Care Facilities for Persons with Mental Retardation (ICF/MR). The ICF/MR facilities are currently serving 465 persons. Many of the individuals that reside in an ICF/MR facility previously were residents of the ND Developmental Center. The ND MFP grant will assist individuals now residing in a community ICF/MR with transition to a more integrated setting in the community as services are available to meet their needs.

During the 1990s a number of programs were initiated that were aimed at further reducing the number of admissions to the Center while enhancing available community services. For instance, the Evaluation, Respite, Intake, and Consultation unit was established to allow a more rapid response to regions referring for admissions and to provide informal intervention to prevent admissions. This was later replaced with the comprehensive Clinical Assistance, Resources, and Evaluation Services program, which was established to ensure high-quality and systematic assistance to private providers and human service centers. Today, the Center continues to provide needed services and supports to consumers living in the community and to their support services providers enabling consumers to be more successful participants in their communities.

In 2005 The North Dakota Legislature directed the Department of Human Services, with input from developmental disabilities service providers, to develop a plan to transfer individuals from the Developmental Center to community placements with transfers beginning in the 2005-2007 biennium. The Department convened the Developmental Center Transition to the Community task force made up of providers, advocates, consumer family members, and various divisions within the Department. The Task Force has been working to build the care infrastructure in the community and to determine the long-term viability and role of the Developmental Center.

The Task Force has developed a draft plan for building community services capacity and an enhanced state wide crisis intervention system. The three subcommittees of this task force are currently working to develop specific strategies to transition individuals from the Developmental Center into the community and divert new admissions to the institution. The MFP Grant Program Administrator is now a member of the task force to support the long term sustainable system changes being recommended to serve persons transitioning from the Developmental Center or community ICF/MR facilities. MFP participants transitioning from the Developmental Center or a community ICF/MR will be supported by the Money Follows the Person Grant for the first year after transition and with supplemental services funds for onetime moving related costs.

Demonstration Objectives

1. Rebalancing: Increasing use of HCBS

   The demonstration service of Nursing Facility Transition Coordination will work cooperatively with nursing facility discharge planning teams to facilitate transitions for qualified consumers who have spent a minimum of six months in a nursing home and/or another institution, meet level of care requirements for nursing facility care, and have been determined to be Medicaid eligible for the thirty day period immediately prior to transition. The Transition

Coordinators along with the discharge planning team will rely on a variety of home and community-based services and supports to make these transitions viable. The Transition Coordinator will provide support for the 365 days following transition to optimize adjustment. Once the transition period has concluded, transitioned consumers will be able to maintain themselves in a community setting through services available under the State's 1915(c) Waivers, the Medicaid State Plan, the Service Payments to the Elderly and Disabled Program, the Expanded Services Payment to the Elderly and Disabled Program, the Older Americans Act, and other community-funded programs.

The grant will financially support additional persons transitioning from the Developmental Center or a Community ICF/MR for the duration of the grant. This financial support will be provided during the first year of transition from the institution with the enhanced rates provided by the grant. The additional Federal funding provided by the grant will be utilized to increase the capacity of the community service system. The Developmental Center Community Transitions Task Force will work with the MFP Grant Administrator to determine the most effective ways to utilize the MFP Grant funds to increase the use of services in the community.

2. Money Follows the Person: Eliminate barriers that prevent/restrict flexible use of Medicaid funds to receive LTC in HCBS.

   In addition to services already offered under North Dakota's 1915 c Waivers, Supplemental services will be made available to ease the transition back into community living for all population groups being served by the grant. These service payments will be for one-time occurrences, such as security deposits, home furnishings, assistive technology, and home modifications. The availability of flexible funding has been shown to make a significant difference in enabling a former nursing facility or ICF/MR resident achieve his or her goal of living in the community.

   The Money Follows the Person Stakeholder Committee and workgroups that have been established are considered vital to the success of the Money Follows the Person Rebalancing demonstration initiatives and in creating long term sustainable system change. The general responsibilities of the committee will be to provide ongoing oversight and/or advice on State policy changes to achieve rebalancing, monitor grant implementation progress, monitor achievement of grant benchmarks, and to suggest ways to improve program design or implementation. The Committee includes consumers and/or their family members, advocacy groups, provider association representatives, State agency staff, and housing agency representatives in a collaborative planning process that can uniquely facilitate change.

The Stakeholder Committee and workgroups have identified barriers to service, gaps in the service delivery system, funding concerns, and policy changes that would eliminate barriers to flexible use of Medicaid funds for the provision of Long Term Care in community settings. The Committee and the workgroups will continue the collaborative efforts that have been established to promote and create sustainable changes to North Dakota's care delivery systems. In addition the Developmental Center Transition to the Community Task Force has established specific strategies to improve services to individuals with a developmental disability and will continue to work with the MFP Grant Manager to implement those strategies.

The Stakeholder Committee has identified the shortage of qualified providers and the limited services available in the community as the primary barriers to achieving the capacity to provide support services at levels needed in the community. These issues encompass the need for training of service providers, recruitment of additional persons to provide services, and the development of additional services to support persons with more challenging needs. The barriers cross services for all population groups and at all levels of service. The intent is long term development of the professionals needed to support persons transitioning during and after the demonstration period. The Direct Service Worker Resource Center (http://www.dswresourcecenter.org/) will be used as a resource to accomplish this goal. North Dakota will address these issues with Money Follows the Person rebalancing funds, maintained in a separate fund, over the life of the grant in the following ways:

Develop recruitment processes to attract new providers for all population groups. This will be accomplished through activities such as:

- Provide informational sessions around the state that would outline the process for becoming a Qualified Service Provider (QSP), define the role of a QSP, and, describe the opportunities available in the state. This process will involve Medical Services Program Administrators establishing a series of informational sessions around the state each year. The sessions will be advertised using public service announcements. The process and informational modules will be developed for long term use in the state's QSP recruitment efforts.

- Fund the Direct Service Professional (DSP) recruitment efforts of state DD service providers. This will involve contracting with a consultant or other services to develop sustainable recruitment strategies. This may include such activities as TV advertising and provision of informational sessions at high schools and colleges, and other locations. The North Dakota Association of Community Facilities will work with the Governor and the Lieutenant Governor about the importance of professionalizing DSP's. NDACF is exploring the possibility of North Dakota Job Service collecting statewide data on DSP's rather than

combining DSP data in a more generic class. NDACF is conducting a wage comparison study, and a staff turnover study, which we will use in developing our platform to bring to the 2009 legislative session, to improve wages and benefits. A second wage comparisons study will be likely after the minimum wage increases in July. Increased wages and benefits will come in the form of a request for alternative funding during the 2009 legislative session. The process will continue in the 2011 legislative session as well to address the ongoing issue of wages and benefits.

- Fund Adult Family Foster Home recruitment efforts by the Department and county social services boards. These efforts will include public service announcements, brochure development, and advertising. This process will be targeted around the state in both metropolitan and rural areas.

- Implement public education strategies to communicate / market the HCBS services available to support continued community residence. This will involve the development and implementation of a marketing plan and/or process that can be utilized around the state.

- Provide/fund a small demonstration grant to a nursing facility to provide personal care in the community. In many of the small ND cities the local nursing facility is the only resource for services of any kind. Current reimbursement rules for nursing facilities create disincentives for nursing facilities to provide community based services such as personal care or other Home and Community Based Services. In addition to the limited population in these communities most qualified care givers are employed by the local nursing facility. To address the reimbursement structure issues that these facilities face a grant would be offered that would allow a nursing facility to offer community based services without compromising their financial situation. This would also provide them with the opportunity to expand their scope of practice and support efforts of the policy changes necessary to make the provision of personal care or other related service a viable means to support persons in the community.

  Grants would be structured to address the administrative and care requirements of expanding services while at the same time utilizing the current rules and regulations, and funding related to the provision of QSP services.

  - Fund recruitment and training efforts for guardians or potential guardians. The intent is long term development of the professionals needed to support persons transitioning during and after the demonstration period.

North Dakota has developed a corporate guardianship service to provide guardianship support to persons with a developmental disability that do not have the capacity to make their own decisions. This is an effective alternative when family and/or friends are not available or willing to serve in this capacity. It would be the preference of the ND courts to appoint a family member or concerned friend if that was possible. Many times family and/or friends are uncomfortable or lack the needed information or training to provide this assistance. The intent would be to develop a recruitment and training process to indentify and educate persons that could provide the needed support of guardianship for persons transitioning from the Developmental Center or a community ICF/MR facility as well as for persons that are transitioning from a nursing facility.

This process would be developed and offered in support of persons transitioning from an institution. The intent would be to develop a training/education process that could be used by institutional providers and community service provides be more successful in guardian recruitment. Once developed it would be useable on an ongoing basis.

- Develop training processes for service providers of all population groups. This will be accomplished by: a) provide training opportunities to service providers in relation to positive behavior interventions to meet the needs of higher need individuals transitioning to the community. To support the efforts of service providers to develop the skills necessary to serve persons with the most significant disabilities specialized training opportunities will be developed and provided. This training will be in addition to the current training curriculum offered to DD provider staff at this time.

- Provide training for individuals to become or to continue as a qualified service provider as defined by N.D.C.C. 50-06.2-02(6) and to provide training to nurses who will provide the training to individuals to become or continue to as a qualified service provider. The QSP recruitment efforts planned are designed to increase the number of providers. This increase in providers will necessitate the demand for training resources and opportunities.

- Develop Behavior Crisis Intervention and Coordination teams and services in ND to provide training, onsite support, and crisis intervention placement services to persons with a developmental disability.

  This initiative will be implemented in 2008 by the Department of Human Services in cooperation with the Developmental Center

Transition to the Community Task Force. The crisis intervention services will be funded with money authorized by the ND legislature to support transitions from the Developmental Center to the community during the 2007 legislative session. Implementation at this time will provide real time information about service delivery costs and benefits of this service model.

The information will to be used to promote long term funding approval from the ND legislature for the Crisis intervention teams and services during the 2009 legislative session. Rebalancing funds will be offered to the legislature as an incentive to offset some of the initial state funding requirements with the goal that the legislature will fully fund the crisis intervention teams for long term.

Over the long term It is proposed that the crisis intervention services be financed through the DD Waiver as an administrative service. While this limits FFP to 50%, providing it as a waiver service would likely not enhance funding: As a result:

- Only services to individuals for whom it is prior authorized could be billed
- Billing would likely need to be for specific services components at 15 minute units
- Rate-setting would be difficult
- Billing/accounting would be burdensome
- Educational/prevention activities not specific to an eligible individual could not be billed/reimbursed.

A method to assist the Crisis Intervention team is for providers to send staff with the person in crisis. This may allow the provider to be paid for the open bed while the person they support is in the crisis unit. If the provider does not send staff, payments to the residential provider would stop.

The Transition to the Community Task Force of the ND Developmental Center has developed long term plans to develop provider/community capacity. The Task Force plan is included for a better understanding of community capacity development actions that will be taken including the entire Crisis Team intervention initiative that will be implemented in 2008. Reference is invited to Appendix J for a full review of the Developmental Center Transition to the Community Task Force Plan.

3. Continuity of Service: Assure continued provision of HCBS after 1-year transition period

The State will assure the continuity of services to all Money Follows the Person Grant participants following their one-year transition period to community living. Participants will continue to receive home and community based services and supports through the State's 1915 c Waivers, the State Plan, and other programs for which they may qualify. Participants who have successfully transitioned to community living and continue to be eligible for HCBS services will be assigned a case manager who will be responsible for coordinating all aspects of a participant's care plan, as well as monitoring the provision of services provided under that plan. The types of case management services available include Home and Community Based Services Case Manager, Developmental Disabilities Case Managers, and Case Managers for persons with a serious mental illness.

North Dakota will continue to work to rebalance long term care funding resources to support consumer preferences for home and community based care with the goal of preventing unnecessary or premature institutionalizations and to allow consumers a wider range of options. Additional customized services under a 1915c Waiver or other funding sources will be assessed and developed based on service needs identified during the MFP grant period and contingent on legislative approval.

The use of a person-centered service planning and delivery model will help to eliminate barriers to the flexible use of services funded by Medicaid. The model is a critical first step in departing from the previous rigidity of service plans that were based on where consumers live, not necessarily on what they need. North Dakota wants to assess support needs first and work to develop a system that can meet those needs with home and community based services.

4. QA/QI: Ensure at least same level of QA for MFP participants as available to other HCBS beneficiaries.

   Quality assurance protocols have been developed for the Nursing Facility Transition Coordination Service, Supplemental Service payments, and the 24 hour on call nursing service to be offered during the grant period. In addition an incident management, risk mitigation, and 24-hour backup services quality protocols have been developed to assure that the health and welfare needs of all MFP participants are addressed in a responsive manner. Processes for these are outlined in the Operational Protocol in more detail. The quality assurance strategies in place for the 1915(c) Waiver services that MFP participants will be receiving are generally outlined as well in the Operational Protocol.

SECTION A.1 – CASE STUDY

The following case studies are intended to show how the ND Money Follows the Person Demonstration Grant services will work from the consumer's point of view.

Case Study for Nursing Facility Transition for a Person with a Physical Disability

Grant population groups receiving Nursing Facility Transition Coordination services include persons with a physical disability or a person that is elderly. Persons with a Developmental Disability that wish to transition from a nursing facility will be provided with transition assistance by either a Developmental Disabilities Case Manager or by the Transition Coordinator depending on service needs.

Elizabeth (Liz) Johnson, age 66, has been residing in the (Good Care) Nursing facility in Bismarck for the past two years. Liz grew up in Wilton and moved to Bismarck after finishing high school. She completed her degree in criminal justice at Bismarck State College and went to work for the Bismarck City Police Department. Liz initially worked as a patrol officer and later transferred to the domestic violence intervention squad where she worked until her retirement at age 55. Liz was married at age twenty five and the couple had three children. Two of her children have moved out of state but her oldest daughter lives in Bismarck with her husband and their two young children.

Liz suffered a spinal cord injury at age 59 and was cared for by her husband at their family home until his sudden death two years ago. Liz moved to the nursing facility at that time with the intention of returning home as soon as arrangements could be made for someone else to assist with her care needs. Liz developed additional health problems which delayed the move home for two years but now is interested in moving back to the community. She has been receiving Medicaid for the last three months and is concerned that she will be unable to move because of the expense of setting up her own place again. Liz's daughters are supportive of her move but they are worried about Liz living alone.

The social worker at Liz's nursing facility reported on her quarterly Minimum Data Set (MDS) assessment that Liz had a preference for returning to the community and that her family was supportive of the move. The ND Money Follows the Persons Grant Program Administrator identified this preference while reviewing the results of the monthly MDS data base probe. Liz's preference was communicated by mail to the Dakota Independent Living Center Transition Coordinator in Bismarck and to her nursing facility social worker by the Money Follows the Person Grant Program Administrator. The Good Care Nursing

Facility social worker and the Transition Coordinator arranged for Liz and her oldest daughter to meet with the Transition Coordinator to discuss the options available through the Money Follows the Person Grant.

The Transition Coordinator met with Liz, her daughter, and her social worker to explain the Money Follows the Person Grant services including Transition Coordination and the Supplemental Services that could help her pay for some of the things she needed to get settled in a place of her own. The various types of qualified living arrangements were explained, and the Transition Coordinator cautioned that the services offered in the Community were not available 24/7 like nursing facility services were. The ultimate decision to move out belonged to Liz, although she could return to a nursing facility if she decided that independent living was not a viable option for her. Liz agreed to work with the Transition Coordinator and the Good Care Nursing Facility discharge planning team toward her goal of community living.

Once the decision to participate was made by Liz, the Transition Coordinator reviewed the MFP informed consent document in detail with Liz and her daughter. The questions that Liz and her daughter had about the risks of participation and the satisfaction surveys were answered by the Transition Coordinator. Liz signed the informed consent document and the necessary authorizations to disclose information (releases of information). Another appointment was set up to start the assessment process.

The Transition Coordinator met with Liz one week later to begin the MFP Transition Assessment process. Liz was able to answer most of the questions on her own but the nursing facility staff also provided additional detail related to the care that Liz receives on a daily basis. Before the assessment was completed Liz indicated that she was feeling very tried so another appointment was set for the following week. The assessment process was completed during the second visit by the Transition Coordinator.

The assessment identified that Liz has a thoracic level spinal injury (T-9) resulting in paraplegia, spastic bladder, and reflex bowel. Liz also was found to have a history of osteoporosis, spasticity, periodic skin break down, and urinary tract infections that require ongoing monitoring and treatment. Liz has a diagnosis of depression that has been treated successfully with an antidepressant and supportive counseling over the last two years. It was found that Liz utilizes an electric wheel chair for mobility. Liz is able to transfer in and out of the chair with the assistance of one person. Liz was found to be receiving therapy three days a week to maintain her upper body strength and to maintain range of motion in her lower extremities. Liz's choice for bladder management was indentified to be intermittent catheterization.

The assessment also noted that Liz needs assistance with bathing, dressing, and toileting. Liz needs assistance with housework, laundry, shopping, and some

meal preparation. Medication set up was identified as important and necessary by Liz and her nursing facility staff.

Liz indicated during the assessment that she was interested in living in an apartment building with other seniors as she is a very social person. Liz preferred remaining in Bismarck so that she was near her daughter. Liz also noted that it was important that she be able to access transportation so that she can visit her friends.

The Transition Coordinator provided Liz with education about the Person Centered Planning process in preparation for a meeting with the nursing facility discharge planning team. Liz indicated that the persons she wanted invited to the meeting included her daughter, her nursing facility care team, and the Transition Coordinator.

The Transition Coordinator worked with the nursing facility social worker to schedule a Discharge Planning Team meeting to review the findings of the assessment, Liz's wishes, and to discuss the service needs that Liz would have in the community. The Transition Coordinator also contacted the Burleigh County Social Services Office to make the Case Management staff aware of Liz's planned move to the community, inquire about Medical Eligibility issues, and to invite the Case Manager to the discharge planning meeting.

The discharge planning meeting was scheduled one week later at the nursing facility. The Person Centered Planning Process was reviewed with the team by the Transition Coordinator. At Liz's direction the Transition Coordinator reviewed the findings of the MFP Transition Assessment. During this review it was identified that Liz would need an Assistive Technology assessment to identify ways for Liz to be as independent as possible once leaving the nursing facility. It was also noted that the community living environment would need to be accessible and may require modification to accommodate Liz's electric chair so that Liz could be more independent. The need for support services to assist with her personal care needs was identified as critical to her success and the maintenance of her overall health. Socialization with family and friends was found to be one of Liz's highest priorities after the move and would require real planning to accomplish. Transportation to social and medical appointments was noted to be needed and likely to be very challenging to set up and to coordinate. Housing options and issues were reviewed in the first discharge planning meeting including concerns about the year long waiting period for a housing voucher approval in the Bismarck area. Adult Foster Care living was reviewed in detail for her consideration. The project based housing options in the area were identified for Liz as an alternative to waiting for a voucher for the apartment alternative. The pros and cons of each choice were discussed for Liz to consider.

The Interagency Program for Assistive Technology (IPAT) Assistive Technology assessment was completed with Liz by discharge planning team members and

forwarded to IPAT for review. IPAT indicated that environmental controls for TV, stereo, DVD, and lights would be very helpful in making her life easier. A medication dispensing machine was also recommended as an option to provide more independence. It was also noted that Liz would benefit from the use of an emergency response system in case of a fall or other similar emergency.

Liz decided that she would like to rent an apartment in one of the senior housing complexes in Bismarck. The Transition Coordinator assisted Liz in making application for housing with the Burleigh County Housing Authority in Bismarck. Liz communicated on her housing application that she had a preference for the "High-rise" apartments on the south end of town. Liz was found eligible and placed on the High-rise waiting list. Liz was informed at that time that the waiting period is usually five or more months in length.

Over the next five months the Transition Coordinator and the nursing facility discharge planning team assisted Liz with identifying her support needs and developing an Independent Living plan for a successful move back to the community. A case manger from Burleigh County Social Services was also involved in the planning process at this time to assist Liz with application for Home and Community Based MFP demonstration services to meet her support needs after her move to the community.

Once Liz was approved for housing a moving date was set and the County Case Manager met with Liz and her discharge planning team to finalize the services that Liz would be receiving in her apartment. Liz was set to move 30 days after being approved for the housing program

The Transition Coordinator assisted Liz with the process of locating Qualified Service Providers to assist her with personal care in her own apartment. Liz and the Transition Coordinator requested a list of QSPs in the Burleigh County area from her HCBS Case Manger. In addition Liz assisted in calling two nieces in Bismarck that expressed interest in helping her out at home. One agreed to become a QSP and the other said she could not help as planned. The Transition Coordinator assisted Liz with the selection of the QSPs that she needed and the scheduling of the QSPs at times most important to Liz.

The Burleigh County Housing Authority offered a congregate meals program in the building where Liz decided to live, so she was able to receive two meals a day during the week. The personal care assistant was scheduled to assist Liz with meal preparation for her evening meal and with meal preparation assistance for her weekend meals.

A weekly nursing visit was also scheduled to assist Liz with medication management and skin care management. This service was arranged through the Burleigh County Nursing Services office.

Liz was approved for a personal care attendant to assist her with bathing, dressing, and toileting, housework, laundry, shopping, and some meal preparation up to four hours per day.

The Transition Coordinator assisted Liz to arrange transportation services with the Bismarck Transit system to transport Liz to her doctor appointments, recreational activities, and to the mall when needed. Liz's and her daughter agreed to assist with doctor appointments when her schedule allowed

The Transition Coordinator assisted Liz with a request to the MFP Program Administrator for Supplemental Service funding to purchase furnishings for her new home, assistive technology to operate her entertainment devises, a modification to the bathroom in her new apartment to make it more accessible for her wheelchair, , and to pay for her utility and security deposits. Once the funding was approved the Transition Coordinator assisted Liz in shopping for and purchasing her furniture, arranging for the bathroom modification to be completed by a contractor, arranging for IPAT to install her environmental controls, and paying her security deposits.

The Independent Living Plan was reviewed and finalized before the move to the community. The risk mitigation and 24 hour backup plans were also developed at this time with the nursing facility discharge planning team. Liz was provided with the 24-hour nursing back-up call service phone number.

The back-up plan developed for Liz included the number of her daughter, of back-up for transportation and personal care if she was home, a listing of the QSPs that agreed to provide coverage if one of the other QSP staff were unable to cover a schedule shift. It included the use of an electronic emergency call system in case of a fall or medical emergency. This information was provided to Liz and forwarded to the 24-hour nursing call service for use in times of need.

Once the Supplemental Services funding was approved the Transition Coordinator assisted Liz in shopping for and purchasing her furniture, arranging for the bathroom modification to be completed by a contractor, arranging for IPAT to install her environmental controls, and paying her security deposits.

Once the needed food and supplies were purchased for Liz's apartment, Liz moved to her apartment with the assistance of her daughter and the Transition Coordinator. It was also agreed that the Transition Coordinator would visit Liz a minimum of twice a week to see how she was adjusting.

In her visits to Liz, the Transition Coordinator observed that Liz was becoming depressed and withdrawn. When the coordinator brought this up with her, Liz admitted that she felt lonely and that it was difficult for her to visit her friends and family as often as she liked. The Transition Coordinator assisted Liz with phone

calls to arrange for more frequent visits with her daughter and to meet weekly with her friends at a restaurant close to her apartment. The coordinator asked Liz if she would like a Senior Companion to visit her twice a week. The Senior Companion would arrange to meet her for lunch or just spend time visiting with her. Liz agreed, and the Transition Coordinator arranged for a Senior Companion to visit. In addition volunteer opportunities in her building were explored by the Transition Coordinator and it was identified that she could be of help by visiting other residents of her building that had recently lost a spouse.

Over the next few months, the Transition Coordinator noticed an improvement in Liz's overall mood. She seemed more engaged with her family and friends and enjoyed participating in some of the activities held in her apartment building. The Transition Coordinator continued to monitor the services Liz was receiving and kept in regular contact with her service providers and family. One morning the relocation coordinator received a phone call from her daughter indicating that Liz was in the intensive care unit in one of the local hospitals, having suffered a minor stoke the previous night.

After her condition was stabilized, Liz was discharged from the hospital to the Good Care Nursing Home for short term rehabilitation with the goal of returning to her apartment. The Transition Coordinator remained in contact with Liz and the nursing home social worker during the two weeks she was in the nursing facility to facilitate a smooth transition back to her apartment. The Transition Coordinator updated the Transition Assessment. Liz, her daughter, the Transition Coordinator, the HCBS Case Manager, and the nursing facility discharge team met prior to her return home to update her backup plan and risk mitigation plan as well as to assure all support services were in place for a successful return. Liz returned to her apartment with additional supports to assist her with bathing, dressing, meal preparation, home care, and all shopping needs due to additional disability because of her stoke.

Within one year of her discharge from the Good Care Nursing Home, Liz was settled in her apartment. The Transition Coordinator communicated the end of the Money Follows the Person Grant eligibility period to Liz and her HCBS Case Manager. The county case manager completed the nursing facility level of care screening assessment in anticipation of Liz's participation in HCBS waiver services and Medicaid State Plan services. The screening agency determined that Liz continued to meet nursing facility level of care screening requirements. Liz was transferred into Medicaid State Plan and HCBS waivered service by the county case manager on the first day post MFP eligibility. Burleigh County Social Services continued providing Liz with case management services after discharge from the MFP process to assure the support services needed to support her community living were still provided to her.

Case Study for the Transition of an Elder from a Nursing Facility

Al is a 78 year old man that has been a resident of a nursing home in Enderlin, ND for the last nine months. Al had been living at his home in Enderlin (population 1,200) with his wife prior to his admission to the nursing home. He entered the nursing home after falling down and breaking his right hip after attempting to walk to the kitchen without his walker. Al and his wife have two children living in Fargo and grand children and great grand children living in the area.

Al was active in the American Legion Club, the Enderlin Golf Club, the local church, and on two bowling leagues over the last fifty years and has many friends in the community. Al enjoyed having coffee with his buddies at the Legion every afternoon before he entered the nursing home.

Al and his wife had agreed that after he was finished with his therapy at the nursing home and he "had his strength back" he would return home to live. Al's children were supportive of the move home but really did not think it would ever happen. Al's son, Philip agreed to act as his Health Care Agent while he was at the nursing home. The nursing home social worker had assisted the family in making his arrangement shortly after Al's admission at the request of Al and his wife.

Al's preference to return to the community and his family's support of this move were identified on his MDS assessment by the MDS Coordinator at the Enderlin Nursing Home when his last assessment was completed. The MFP Program Administrator identified his preference during the monthly data probe. Al's name as a potential MFP participant was forwarded by mail to the Transition Coordinator at the Freedom Inc. Independent Living Center in Fargo and the Enderlin Nursing Facility Social Worker as being eligible for MFP grant services.

The Transition Coordinator called the Enderlin nursing facility social worker and arranged an appointment to meet with Al, his wife, his son Philip, and the social worker to review the MFP grant services. The appointment was set-up at the convenience of the family one week later in Al's room at the nursing facility. The nursing facility social worker provided Al with the MFP brochure to review in preparation of the meeting.

The Transition Coordinator arrived at the Enderlin nursing facility as planned one week later and met with Al, his wife, his son Philip, and the nursing facility social worker. The MFP grant process was reviewed and Al and his family were provided with the MFP brochure, MFP Rights brochure, MFP Fact Sheet, and MFP Role Matrix. Concerns about Al's ability to return home safely were discussed at length by the group. The nursing facility social worker shared that Al had been faithful to his scheduled therapy and has voiced a strong desire to move back home with his wife. Al's wife and son were more skeptical but

admitted that they would like to see Al return home if proper supports could be arranged. Al agreed that he wanted to attempt to move home so he signed off on the MFP consent document and a release of information for both the nursing home and the Ransom County Social Services Office.

The Transition Coordinator made an appointment with Al and his wife to begin the MFP Transition Assessment later that week. The Transition Coordinator and the nursing facility social work arranged for a review of Al's chart and the initial discharge planning meeting to review Al's assessment.

Al and his wife met with the Transition Coordinator later that week as planned and were able to complete the assessment with the assistance of Al's nurse and social worker. Al's wife indicated that she was still worried about the move home but felt "a little better" after better understanding the type of assistance Al would need at home. Al and his wife agreed to attend the first discharge planning meeting the following week.

The Transition Coordinator worked with Al to identify the persons that he wanted at this discharge planning meeting. Al was able to communicate that he wanted his normal care team, his family, and the "therapy folks" at the meeting. The discharge planning team, including Al's normal care team members and the physical therapist met with Al, his wife, his son Philip, the nursing facility social worker and the Transition Coordinator. The Transition Coordinator made the team aware that she had contacted Ransom County Social Services and the Case Manager indicated that Al will not have any problems maintaining Medicaid eligibly if he returns home and that she will be happy to attend future planning meeting closer to the time when Al is going to move home.

The MFP assessment results were reviewed with the team with a few corrections made due to Al overestimating his ability to care for his own needs. The team identified that Al would have support needs that could not be met by his wife to include assistance with bathing three times per week, range of motion exercises and some walking to maintain his strength, and assistance with his insulin shots on a daily basis. It was also agreed that Al would benefit from an emergency response system in case he fell again when his wife was away from the home. The team also felt that a ramp for the family home would be helpful so that Al would not have to climb the five steps into the home. The family home also needed modifications to the bathroom and kitchen so Al could be as independent as possible with toileting and meal preparation. It was noted that Al also wanted to be able to go see his buddies at the Legion Club a couple days a week so he did not feel so "cooped up" all the time. Transportation was noted to be a concern because Al was no longer able to drive himself downtown.

The team additionally reviewed the risk and mitigation needs and 24-hour backup plan issues that would need to be addressed before transition. A meeting was set-up with Al and his wife and son to develop the Initial Independent Living Plan.

Al, his wife, and his son Philip met with the Transition Coordinator and developed his initial Independent Living Plan. The group established goals, action steps, and assigned responsibility for each of the task to be completed. Goals were developed related to Al's need to identify services to assist with bathing and exercise, the need to indentify transportation options to the local Legion Club, the need to secure assistance with his daily insulin shot, the need to secure the funding for the needed home modifications, and the need to secure the emergency response system.

In reviewing the risk mitigation related issues it was determined that preventing future falls and maintaining Al's health were the top priorities. The family also was able to list several family friends that could assist as backup if Al's wife was ill or away or if something occurred to Al requiring help in the evening. Al and his family agreed that if the arrangement could be made to keep him safe that they would support a move home in a "few months."

Al, his wife, and the Transition Coordinator meet with the Ransom County Social services HCBS Case Manager in his room to discuss services to assist with Al's bathing, his daily insulin shot, home modifications, and the emergency response system as these services are normally covered under the HCBS waiver and would be MFP demonstration services if Al transitions home. The county case manager provided a list of the QSPs in Ransom County including two different home health agencies that could provide the needed assistance with bathing, exercise, and the daily insulin shots. The emergency response system was discussed and the family was referred to the IPAT Agency to secure the system. The contractors in the area that could complete home modification under the MFP demonstration were identified so that work could be initiated on this task.

The case manager agreed to attend the next discharge planning meeting to begin formal assessment and service plan development for HCBS. The Transition Coordinator provided the case manager with a copy of the MFP Assessment for her use in preparing for services.

The Transition Coordinator and Al and his family made contacts with the local contractors about the home modifications needed and arranged to have the work completed. Al, his wife, and the Transition Coordinator met with the two home health agencies and discussed Al's needs. Al selected the agency that had several staff that lived in Enderlin and he was familiar with their family members. IPAT was contacted by Al's son Philip and arrangements were made to have the emergency call system installed if and when Al moved home. Transportation to the Legion three days per week was more difficult to arrange than expected as there is no transit system in Enderlin and most of his friends are not able to assist routinely. After a great deal of searching, two men from the local senior center agreed to provide the ride for a small fee each week.

The nursing facility discharge planning team met with Al, his wife, his son Philip, the Ransom County Case Manager, and the Transition Coordinator to discuss the progress on the Independent Living Plan goals. It was noted that all the work needing to be completed for the move was almost finished. The county case manger had been in contact with the nursing facility social worker and the NF LOC screening document was completed and Al was found to continue to meet LOC requirements and her assessment noted he was in need of HCBS services. The team finalized the risk mitigation plan and 24 hour back-up plans. It was agreed that Al would be ready to move home once the home modifications were completed. The work on the modifications was scheduled to be complete within two weeks. A tentative move date was set for three weeks later.

The risk mitigation plan targeted Al's need for a safe home environment to prevent falls and included the emergency response system if he did fall while alone. The back-up plan included a list of several neighbors, four grand children, Al's son, and three of the home nursing agency staff that lived in Enderlin. Al was also provided with the 24-hour backup nurse call phone number.

The Transition Coordinator remained in contact with the nursing facility social worker, Al, and his family as the final arrangement for his move was completed. Al's wife started to get "cold feet" about the move so the Transition Coordinator visited with her at her home to address her concerns. Al's son Philip remained very supportive of the move and agreed to discuss the move in a positive manner with his mother after a conversation with the Transition Coordinator.

When all parties were able to support Al's move home a firm move date was set. Arrangements were made for his prescriptions to be filled at the local pharmacy and an appointment was set up with his physician for the following week at the local clinic. The home nursing agency was contacted and arrangements were made for care to begin the day of Al's move home. The emergency response system was installed and the final touches on the modifications to the house were made by the contractor. Al's son Philip agreed to transport Al home.

The moving day arrived and Philip transported Al to his home. The Transition Coordinator met with the family at their home that afternoon and agreed to visit weekly to address any concerns or problems with the planned support services.

Two weeks into to the return home it was found that Al needed more assistance than expected with hygiene so a meeting was setup with his county case manager to review services. Based on the increased need it was agreed that Al would receive additional personal care assistance each day to assist him with dressing and personal hygiene due to occasional incontinence. The Independent Living Plan was updated at this time to reflect Al's increased need.

Al responded to the additional care in a very positive manner and Al's wife indicated that she had been thinking that Al should return to the nursing home before the additional assistance was started.

The Transition Coordinator continued to meet with Al and his wife weekly for two months and as services were more stable decreased to monthly visits for the next several months. After services were more stable and Al was doing well the Transition Coordinator decreased her visits to once every two months.

One month before Al's MFP eligibility was completed, the Transition Coordinator notified Al and his family and the Ransom County Case Manger of the ending date of MFP services. The county case manager updated Al's NF LOC screening and found that he continued to meet screening criteria. The Transition Coordinator met with Al and his wife one last time with the case manger to be sure all work was completed for his transfer to waivered services. Al completed his 365 days of eligibly and was transferred to HCBS and Medicaid State Plan personal Care services on day 366.

Case Study for Transitions from the Developmental Center or a Community Intermediate Care Facility for the Mentally Retarded (ICF/MR)

The grant population being served will be persons with a developmental disability.

Sue Jones is a 44 year old woman that has been a resident at the ND Developmental Center the last 35 years. Sue has been assessed to be functioning in the mild range of mental retardation. Sue is the oldest of three children born to Al and Jean Jones of Kindred. Sue's family cared for her at home until she began having frequent seizures that were difficult for her family to manage. Sue moved to the Developmental Center at the age of nine.

Sue had a difficult time adjusting to life with others at the Developmental Center because of her confrontational behaviors. Sue would yell at other residents when they would touch her belongings or interrupt her activities

Sue's parents act as her limited guardians and have remained involved in her support planning process. Her parents continued to visit Sue over the years while she lived at the Developmental Center. Both of her parents were interested in Sue moving closer to home. Sue's family wanted Sue to move to Fargo "some day" and begin receiving support services from a community provider in Fargo. Sue also had discussed wanting to live closer to her family and "getting a job".

While at the Developmental Center, Sue worked or volunteered in various roles including piece work at the Center workshop, cleaning crews at the Center, and

as a hotel housekeeper on a community work crew. Sue indicated that she especially enjoyed the hotel work.

Sue's support team has been discussing the option of a transition to the community with her for some years. Once her seizure disorder was better controlled and she had responded well to the positive behavior supports, Sue's team felt the community transition needed to be considered. A Resident Decision Profile (RDP) rating scale was completed by Sue, her parents, Sue's Developmental Disabilities Case Manager, and her support team. Sue scored a total of six on the RDP and it was determined all parties agreed that her support needs now could be met in a community placement.

During the support team meeting the Developmental Center's social worker visited with Sue and her family about the service options available in the Fargo area and the Money Follows the Person Grant services available to support Sue's move to the community. Sue's parents initially were concerned about the move to Fargo due to fears that Sue would not have the same 24 hour support that she had at the Developmental Center. This was discussed at length with the social worker. It was agreed that it would be helpful if Sue and her family toured the service providers programs and met with her DD Case Manager to discuss support services options.

Sue and her family consented to participate in the MFP Grant during the Support Plan meeting. Sue's Developmental Disabilities Case Manger from the Southeast Human Service Center in Fargo and the Developmental Center Social Worker worked with Sue, her family, and the Fargo community providers to arrange a tour of the vocational programs and residential options available. The tour went well, allowing Sue and her parents to get the additional information that they needed to feel comfortable about the move and to select the community providers she wished to provide her with the supports needed to make a successful transition.

Sue, her parents, her Developmental Center support team, her DD Case Manger, and the community vocational and residential providers held a meeting by teleconference to discuss her goals and the specific supports needed in the community. Control of Sue's seizure disorder was identified as the most concerning issue by Sue's parents. It was reported by the Developmental Center nurse that Sue was having about four grand mal seizures per month on her current medication. It was identified that Sue was cooperative with taking her medication but would need reminders or prompts from staff if living in the community. The social worker reported that Sue used a deep breathing relaxation routine to help her calm herself when upset or stressed. After a great deal of discussion about the need to maintain consistent medication compliance and management of her stress levels it was agreed that she would need supports to address both of these issues. It was determined that staff would be scheduled to assist with medication compliance and health monitoring. Staff that assisted

Sue in her home and at work would both assist Sue with the ongoing practice of the relaxation techniques she had learned.

Sue indicated that she wanted to work as a housekeeper at a hotel in Fargo if that could be arranged. Sue agreed to work with the vocational services provider to secure a job initially as a housekeeper at a local hotel with one of their work crews. As Sue become more skilled she would be assisted in finding a job as a housekeeper on her own.

Assistive technology needs were discussed by the team as well. The IPAT assessment was completed and sent to IPAT for review. IPAT suggested the use of a medication dispensing devise that could eventually allow Sue to be more independent with her medications.

The teams agreed that an apartment with Individualized Supported Living Arrangement Services (ISLA) would be the best option to meet Sue's various needs. Sue and her parents were made aware of the one year long waiting list for Section 8 vouchers to assist her with rent costs. Group Home options and Adult Foster Care were also discussed and offered. The Section 8 housing project based sites were also reviewed and discussed as alternatives. Sue and her family were assisted in filing an application for housing in the Fargo area. The project based apartment buildings were visited with the service provide and DD Case Manager Sue decided that she wanted to move to one of the apartment buildings with project based housing assistance as the waiting list was only about six months long.

Five months after her application Sue was made aware that an opening in one of the project based housing sites would be available within a month. Sue and her parents' expressed concern again about Sue's readiness for the move. DC staff and the DD Case Manager both reviewed these concerns and the right to remain at the DC. This required two separate meetings and one additional site visit to Sue's apartment before all parties felt comfortable with the transition. A moving date was set and the risk mitigation and 24 hr. back-up plans were developed with Sue in preparation of her move.

Sue's back-up plan was developed to include a listing of ISLA staff to call if one of her staff does not show as scheduled. The numbers of her parents and siblings were also provided to assist with transportation concerns. The ISLA emergency contact numbers were also provided to her. She was reminded of the 911 system and its need to be called in the case of a medical emergency.

A request for Supplemental Services to purchase the furnishings, home supplies, and assistive technology needed for her apartment was submitted by her ISLA provider to the MFP Program Administrator. The DD Case Manager, the DC Social Worker, and the community providers finalized the necessary paperwork

and a moving date was set. The community provider assisted Sue with the purchase of her furnishings and other apartment supplies. Sue's parents, her siblings, and staff from the ISLA program assisted Sue with the move to her apartment.

Sue's community providers and her DD Case Manager met periodically with Sue and her family for planning meetings to adjust the positive behavior supports provided as Sue adjusted to the new challenges of living in the community. Sue's risk mitigation plan and 24 hour backup plans were also reviewed during all planning meetings, after all critical incidents, and at least one time every six months after transition.

After Sue was living in her apartment for six months a critical incident occurred involving a fall resulting in a broken arm. Sue's DSP reported that Sue had been getting out of her van after completing the grocery shopping for the week. Sue began complaining of pain in her right arm shortly after the fall so the DSP contacted her supervisor and Sue's family and made them aware of the fall and provided Sue with a ride to the hospital emergency room. An x-ray was completed and it was found that Sue had a minor fracture in her radius bone. A cast was applied and Sue was discharged from the hospital. Sue was still able to manage her own basis self-care but with some difficultly. Sue also expressed concern about her ability to complete her housekeeping work at home and on the job.

The DSP contacted her supervisor after returning from the hospital to alert her to Sue's changed needs. Arrangements were made for additional staff time to assist Sues with at home the next several days while she was away from her job and in need of more assistance at home. The DSP completed a critical incident report and turned it in to her supervisor. The supervisor completed an investigation of the incident to evaluate the circumstances of the fall and possible preventative measures to take to prevent any future falls. The investigation found that Sue fall was the result of a loss of balance. Recommendations about adding a stabilizing handle to the vehicle door was recommended and arranged to prevent future falls. This was added to Sue's support plan.

The support team was called together to review Sue's changed needs as the result of her fall and broken arm. The 24 hour backup system was found to have worked well in addressing the incident so no changes were made to that plan. The risk mitigation plan was reviewed and it was found that Sue had increased risk for emotional stress due to being away from work and being more dependent on staff for assistance and needed additional staff assistance with self care and home care. Plans were put in place to provide additional support in her apartment for an additional two weeks to help Sue manage the time away from work and to complete her housekeeping tasks and care tasks.

The team met again two weeks later to address Sue's improved health situation and reduced the staff time and assistance she was receiving. Sue was able to return to work with minor accommodations.

Sue was able to continue in community services throughout the first year after transition. Near the end of her 365 days of Money Follows the Person demonstration eligibility Sue, her parents and the DD Case Manager were made aware that the grant period for Sue was ending. The DD Case Manager updated the ICF/MR screening information/assessment and she was found to meet eligibility requirements. On day 366 Sue was transferred to DD waiver service funding. Sue continued to receive the same support services in her effort to continue her successful transition.

SECTION A.2 – BENCHMARKS

The following are the five benchmarks that will be measured for the North Dakota's Money Follows the Person Demonstration.

Benchmark #1: Projected number of eligible individuals to be assisted in transitioning

The following table represents the projected number of eligible individuals in each target group to be assisted in transitioning from an inpatient facility to a qualified residence during each year of the demonstration beginning June 1, 2008. Individuals included in the "other" category are children that are expected to transition into the Medically Fragile Children's Waiver.

Grant Year	Aged	Physically Disabled	Individuals with MR/DD	Dual Diagnosis: MR / DD and MI	Other	TOTAL
2007	0	0	0	0	0	0
2008	10	4	5	0	1	20
2009	11	13	8	0	1	33
2010	11	13	8	0	1	33
2011	10	4	9	0	1	24
TOTAL	42	34	30	0	4	110

Benchmark #2: Qualified expenditures for HCBS during each year of the demonstration program

Institutional vs. HCBS Expenditures

	CY 2007	CY 2008	CY 2009	CY 2010	CY 2011
Total NF Expenditures	193,260,930	204,156,910	216,417,990	226,829,980	237,390,890
DD/MR Expenditures	73,595,395	75,982,672	76,946,660	76,430,428	74,615,587
	266,856,325	280,139,582	293,364,650	303,260,408	312,006,477
Decrease in NF Expenditures	-	900,692	1,591,309	1,667,868	1,047,313
Decrease in DD/MR Expenditures	-	556,539	1,518,780	1,518,780	1,277,959
	-	1,457,231	3,110,089	3,186,648	2,325,272
% Decrease to Institutional		**0.52%**	**1.06%**	**1.05%**	**0.75%**
HCBS Expenditures	11,331,300	11,842,319	12,373,779	12,868,730	13,383,479
MR/DD Expenditures	87,171,903	91,102,877	96,431,606	103,262,463	111,501,857
	98,503,203	102,945,196	108,805,385	116,131,193	124,885,336
NF MFP Expenditures	-	688,163	2,385,149	2,024,689	964,634
MR/DD MFP Expenditures	-	444,098	1,240,516	1,288,979	1,135,303
	-	1,132,261	3,625,665	3,313,667	2,099,936
% Increase to HCBS		**1.10%**	**3.33%**	**2.85%**	**1.68%**

CY 2008 figures changed to include the full 365 days in the comparison, not just the days related to the MFP grant.

Benchmark #2 estimates the percentage increase in Home and Community Based Services funding and the percentage decrease in Institutional Expenditures. The base year for comparison is 2007. Factors considered when establishing this benchmark include decrease in occupancy due to MFP clients and increase in rates.

This benchmark is based on 2007 baseline numbers. Nursing Home baseline figures are calculated on 2007 census projection times the average daily rate for nursing homes. Developmental Disabilities baseline figures are calculated on budgeted yearly expenditures. All costs include a 4% yearly increase based on the average historical increase granted by the State Legislature. Home and Community Based Services expenditures are based on historical costs trended forward including the 4% yearly increase and caseload increases related to Money Follows the Person clients.

The increase in Nursing Home expenditures from CY 2008 to CY 2009 is due to the rebasing of nursing home rates and nursing home rate limits. According to State Statute, in 2009 the nursing home rate limit must be recalculated based on the most recent available nursing home cost reports.

Nursing Facilities/Developmental Disabilities expenditures decreased from calendar yar 2010 to 2011 because CY 2011 figures only include expenditures through September 30, 2011, the end of the Money Follows the Person Grant. The decrease in institutional expenditures over the life of the Grant is due to the estimated decrease in utilization due to the transition of Money Follows the Person clients.

Benchmark #3: Develop Behavior Crisis Intervention and Coordination

Develop Behavior Crisis Intervention and Coordination teams and services in ND to provide training, onsite support, and crisis intervention placement services to persons with a developmental disability.

The Transition to the Community Task Force of the ND Developmental Center has developed long term plans to develop provider/community capacity. The Task Force plan is included for a better understanding of community capacity development actions that will be taken including the entire Crisis Team intervention initiative that will be implemented in 2008. Reference is invited to Appendix J for a full review of the Developmental Center Transition to the Community Task Force Plan.

Crisis Intervention

GOALS:

1. To design a Crisis Intervention model that is statewide
2. That the Crisis Intervention model should have two major components:
    a. Be proactive and focus on prevention
    b. Be reactive and be responsive
3. That the Crisis Intervention service will be based on a “zero reject” model

CRISIS INTERVENTION (CI) SERVICES INCLUDE:

Residential Services

1. In-Home Technical Assistance
2. Follow-Along Services after Out-of-Home Crisis Residential Services placement
3. Training for community professional and direct support staff
4. Crisis beds
5. Out-of-Home Crisis

This initiative will be implemented in 2008 by the Department of Human Services in cooperation with the Developmental Center Transition to the Community Task Force. The crisis intervention services will be funded with money authorized by the ND legislature to support transitions from the Developmental Center to the community during the 2007 legislative session. Implementation at this time will provide real time information about service delivery costs and benefits of this service model.

The information will to be used to promote long term funding approval from the ND legislature for the Crisis intervention teams and services during the 2009 legislative session. Rebalancing funds will be offered to the legislature as an incentive to offset some of the initial state funding requirements with the goal that the legislature will fully fund the crisis intervention teams for long term.

Over the long term it is proposed that the crisis intervention services be financed through the DD Waiver as an administrative service. While this limits FFP to 50%, providing it as a waiver service would likely not enhance funding: As a result:

- Only services to individuals for whom it is prior authorized could be billed
- Billing would likely need to be for specific services components at 15 minute units
- Rate-setting would be difficult
- Billing/accounting would be burdensome
- Educational/prevention activities not specific to an eligible individual could not be billed/reimbursed.

A method to assist the Crisis Intervention team is for providers to send staff with the person in crisis. This may allow the provider to be paid for the open bed while the person they support is in the crisis unit. If the provider does not send staff, payments to the residential provider would stop.

Implementation Plan:

2008-Develop Bismarck Crisis Intervention Site
Persons to be served by Crisis Intervention Sites

Developmental Center Crisis Intervention Site Admissions

2008	2009	2010	2011
18	20	25	25

Developmental Center Crisis Intervention Care Consultations

2008	2009	2010	2011
25	25	30	30

Bismarck Crisis Intervention Site Admissions

2008	2009	2010	2011
5	10	15	15

Bismarck Crisis Intervention Site Care Consultations

2008	2009	2010	2011
10	15	20	20

Benchmark #4: Develop and Implement Plans to Educate Consumers

To assist in rebalancing the state's long term care system, the MFP Stakeholder Committee will develop and implement plans to educate consumers of rebalancing efforts, provide information to the ADRC on available resources, and identify activities and services lacking in communities. Additionally, the committee will develop a plan of action to enhance services in underserved areas of the state.

North Dakota currently ranks in the bottom third in the nation related to spending on HCBS services. This is especially significant as the percentage of spending for LTC services in the community is only 25% of what is now being spent on institutional LTC services. The MFP Stakeholder Committee is in the unique position of having all of the needed stakeholders at the table to address the system changes necessary to address this spending imbalance. Sustained collaboration of all stakeholders will be vital to the implementation of long term changes that will optimize choice and quality of life for the citizens of the state.

The Committee will develop and implement a plan of action to educate consumers of rebalancing efforts, provide information to the ADRC on available resources, and identify activities and services lacking in communities. Additionally, the committee will

develop a plan of action to enhance services in underserved areas of the state. These activities are in addition to the ongoing MFP Stakeholder Committee activity of grant protocol development and implementation oversight. The Committee will begin meeting in August of 2008 to address the education and service development plan activities. The Committee will meet quarterly and its efforts will be supported by the MFP Grant funds.

The Committee will meet quarterly for the purpose of identifying activities and services lacking in communities around the state, developing and implementing plans of action to enhance services in underserved areas of the state. The Stakeholder Committee will develop an action plan to enhance services in the underserved areas of the state by August 2009. This plan will be reviewed quarterly and adjusted as needed to address changing community needs. Committee members will report quarterly on the activities they have engaged in over the previous quarter to enhance services.

Action Plan One:

August 2009-Action Plan finalized outing lining goals and objectives to enhance services in underserved areas of the state

Projected increase in the numbers of persons served by HCBS in the 10 most underserved counties in the state

2009	2010	2011
5	10	15

According to the **"**Population Projections: 2005 to 2020, Leading Trends Influencing North Dakota's Future Population**"** from the *North Dakota State Data Center,* North Dakota's population grew only slightly over the past decade. The data they sited from the 2000 Census indicated that the state grew by 0.5 percent between 1990 and 2000 reaching a population base of 642,200. This is the smallest relative growth of all 50 states. The three leading trends outlined in the Center's report that are seen to influence the state's future population and comprise the underlying assumptions used to project future county populations within North Dakota are rural depopulation, out-migration of young adults and young families, and an increasing proportion of elderly. Based on this census information the utilization of Home and Community Based services by consumers in North Dakota counties with a population of 10,000 or less was evaluated to determine the most underserved areas of the state. The following table reflects the spending and related census information of the ten counties determined to have the most need of enhanced services based on current services provided and projected population of persons age 65 and older:

County	2005-2006 Spending on SPED, EX SPED, A & D Waiver, Personal Care, & TDI Waiver	2006-2007 Spending on SPED, EX SPED, A & D Waiver, Personal Care, & TDI Waiver	Number of persons 65 and older in 2000	Money spent per person 65 and over	Percent of Population over 65 in 2000	Projected number of persons 65 and older in 2010	Projected number of persons 65 and older in 2015
Cavalier	25,393	31,516	1,057	$29.81	25.6%	1,148	1,220
Foster	8,053	8,983	715	$12.57	21.7%	887	957
Grant	20,128	17,419	642	$27,13	25.1%	707	735
Kidder	1,615	722	630	$01.15	23.3%	683	684
McHenry	22,919	15,643	1,252	$12.49	20.6%	1,446	1,584
McIntosh	21,503	25,993	1,008	$25.79	34.5%	1,216	1,227
McKenzie	31,041	27,923	848	$32.92	15.3%	1,118	1,300
Oliver	9,418	9,914	302	$32.82	21.3%	342	423
Renville	15,144	12,734	514	$17.74	21.5%	578	616
Sargent	18,016	12,583	718	$17.53	18.3%	896	983

Source U.S. Census Bureau: State and County Quick Facts. Data derived from Population Estimates, Census of Population and Housing, Small Area Income and Poverty Estimates, State and County Housing Unit Estimates, County Business Patterns, Nonemployer Statistics, Economic Census, Survey of Business Owners, Building Permits, Consolidated Federal Funds Report

The numbers of individuals served in the SPED, Expanded SPED, Waiver, Personal Care, and county funded programs in the counties of Cavalier, Foster, Grant, Kidder, McHenry, McIntosh, McKenzie, Oliver, Renville, and Sargent was also examined over the last two quarters of 2007 and the first two quarters of 2008 to establish a baseline to measure the increase in number of persons served in these counties. This information was tracked using North Dakota's Social Assistance Management System (SAMS) which is utilized by all county case managers for consumers receiving Home and Community Based Services in the state. The following four tables establishes a baseline for services provided in all ten counties and will be utilized to measure the increase in the number of persons receiving HCBS in each county.

Quarter 3 07/01/07 to 09/30/07

		SPED			Expanded SPED			WAIVER			COUNTY FUNDED			MA PERSONAL CARE		
#	County	**Total Cases**	# New	# Closed	**Total Cases**	# New	# Closed	**Total Cases**	# New	# Closed	**Total Cases**	# New	# Closed	**Total Cases**	# New	# Closed
	Total	**62**	10	5	**1**	0	0	**4**	1	0	**96**	8	9	**22**	3	3
1	Cavalier	8	1	3	0	0	0	0	0	0	2	0	1	1	1	0
2	Foster	4	1	0	1	0	0	0	0	0	15	0	1	1	1	0
3	Grant	6	0	1	0	0	0	0	0	0	9	0	1	3	0	0
4	Kidder	1	0	0	0	0	0	2	1	0	0	0	0	3	1	0
5	McHenry	11	4	0	0	0	0	1	0	0	11	1	3	3	0	0
6	McIntosh	11	2	0	0	0	0	1	0	0	5	0	0	1	0	2
7	McKenzie	6	0	0	0	0	0	0	0	0	35	4	1	6	0	0
8	Oliver	5	0	0	0	0	0	0	0	0	0	0	1	3	0	0
9	Renville	5	1	0	0	0	0	0	0	0	6	1	0	0	0	1
10	Sargent	5	1	0	0	0	0	0	0	0	13	2	1	1	0	0

Quarter 4 10/01/07 to 12/31/07

		SPED			Expanded SPED			WAIVER			COUNTY FUNDED			MA PERSONAL CARE		
#	County	**Total Cases**	# New	# Closed	**Total Cases**	# New	# Closed	**Total Cases**	# New	# Closed	**Total Cases**	# New	# Closed	**Total Cases**	# New	# Closed
	Total	**67**	5	4	**1**	0	0	**2**	0	2	**90**	4	6	**21**	2	4
1	Cavalier	9	2	1	0	0	0	0	0	0	2	0	0	2	1	0
2	Foster	4	0	0	1	0	0	0	0	0	15	1	1	2	0	0
3	Grant	6	0	0	0	0	0	0	0	0	9	0	0	3	0	0
4	Kidder	1	0	0	0	0	0	1	0	1	0	0	0	1	0	2
5	McHenry	14	0	0	0	0	0	1	0	0	9	0	0	3	0	0
6	McIntosh	13	3	1	0	0	0	0	0	1	5	1	0	1	0	0
7	McKenzie	4	0	2	0	0	0	0	0	0	34	2	4	5	0	2
8	Oliver	6	0	0	0	0	0	0	0	0	0	0	0	3	1	0
9	Renville	5	0	0	0	0	0	0	0	0	6	0	0	0	0	0
10	Sargent	5	0	0	0	0	0	0	0	0	10	0	1	1	0	0

Quarter 1 01/01/08 to 03/31/08

		SPED			Expanded SPED			WAIVER			COUNTY FUNDED			MA PERSONAL CARE		
#	County	**Total Cases**	# New	# Closed	**Total Cases**	# New	# Closed	**Total Cases**	# New	# Closed	**Total Cases**	# New	# Closed	**Total Cases**	# New	# Closed
	Total	**68**	7	3	**1**	1	0	**2**	0	0	**89**	3	3	**21**	2	1
1	Cavalier	10	3	1	0	0	0	0	0	0	2	0	0	2	0	0
2	Foster	3	0	1	1	0	0	0	0	0	13	0	2	1	0	1
3	Grant	7	1	0	0	0	0	0	0	0	9	0	0	3	0	0
4	Kidder	1	0	0	0	1	0	1	0	0	0	0	0	1	0	0
5	McHenry	14	0	0	0	0	0	1	0	0	8	0	0	4	1	0
6	McIntosh	12	1	0	0	0	0	0	0	0	5	0	0	1	0	0
7	McKenzie	4	0	1	0	0	0	0	0	0	34	0	0	5	1	0
8	Oliver	8	2	0	0	0	0	0	0	0	0	0	0	3	0	0
9	Renville	5	0	0	0	0	0	0	0	0	5	0	1	0	0	0
10	Sargent	4	0	0	0	0	0	0	0	0	13	3	0	1	0	0

Quarter 2 04/01/08 to 06/30/08

		SPED			Expanded SPED			WAIVER			COUNTY FUNDED			MA PERSONAL CARE		
#	County	**Total Cases**	# New	# Closed	**Total Cases**	# New	# Closed	**Total Cases**	# New	# Closed	**Total Cases**	# New	# Closed	**Total Cases**	# New	# Closed
	Total	**73**	6	6	**3**	2	0	**3**	0	0	**94**	8	4	**22**	0	1
1	Cavalier	9	0	1	0	0	0	0	0	0	2	0	0	1	0	1
2	Foster	3	0	0	1	0	0	0	0	0	14	1	0	1	0	0
3	Grant	6	0	1	0	0	0	0	0	0	9	0	1	3	0	0
4	Kidder	3	2	0	2	2	0	1	0	0	0	0	0	1	0	0
5	McHenry	18	1	1	0	0	0	1	0	0	8	1	0	5	0	0
6	McIntosh	13	1	1	0	0	0	0	0	0	5	0	0	1	0	0
7	McKenzie	5	1	0	0	0	0	0	0	0	36	3	1	5	0	0
8	Oliver	7	0	1	0	0	0	1	0	0	0	0	0	4	0	0
9	Renville	3	0	1	0	0	0	0	0	0	4	0	1	0	0	0
10	Sargent	6	1	0	0	0	0	0	0	0	16	3	1	1	0	0

Acton Plan Two:

April 2009-Education Action Plan finalized outlining annual goals and objectives
July 2009-Education Action Plan implemented

Projected percentage increase in the number of individuals served statewide in the community by Home and Community Based Services.

2009	2010	2011
2%	3%	4%

The Committee will be comprised of the ND MFP Stakeholder Committee members including individuals representing Governor's Olmstead Commission, Home Health, consumers/family members, Housing Finance Agency, CIL's, Public Health, Senior Centers, Older American Act Providers, County Social Service Board Directors, Long Term Care Association, North Dakota Center for Persons with Disabilities, licensed DD community providers, and other interested parties.

The Committee will also develop a community education plan by April 2009 outlining annual goals and objectives to educate consumers of rebalancing efforts, provide information to the ADRC on available resources, and educate consumers about available community resources. Committee members will report quarterly the actions that they have taken to implement the education plan.

The goal of the state to increase the percentage of persons serviced in the community by Home and Community Based Service is based on statewide counts. It is our intention to increase the number of persons receiving services across the state through the implementation of our public education plan.

The number of persons that were served in North Dakota by Home and Community Based Servicers in 2007 and in 2008 is as follows:

	SPED	Ex-SPED	A&D Waiver	TBI Waiver	Tech Dep Waiver	Personal Care	DD Waivers	Total
Jan-07	1,323	115	210	27		587	2,402	
Feb-07	1,342	115	236	27		586	2,354	
Mar-07	1,321	113	235	27		579	2,399	
Apr-07	1,327	112	226	27		565	2,426	
May-07	1,410	114	232	26		606	2,467	
Jun-07	1,362	110	231	27		602	2,414	
Jul-07	1,335	113	216	27		551	2,354	
Aug-07	1,371	110	223	28	1	588	2,770	
Sep-07	1,391	105	207	28	1	584	2,916	
Oct-07	1,484	111	229	20	1	573	2,903	
Nov-07	1,424	115	219	21	1	534	2,821	
Dec-07	1,471	102	226	28	1	549	2,833	
	16,561	**1,335**	**2,690**	**313**	**5**	**6,904**	**31,059**	**58,867**
							Monthly Average	4,906

	SPED	Ex-SPED	A&D Waiver	TBI Waiver	Tech Dep Waiver	Personal Care	DD Waivers	Total
Jan-08	1,406	106	199	28	1	559	2,871	
Feb-08	1,448	112	218	29	1	566	2,873	
Mar-08	1,457	108	220	29	1	564	2,862	
Apr-08	1,476	113	224	28	1	570	2,886	
May-08	1,459	111	217	30	1	572	2,469	
Jun-08	1,407	107	212	28	1	567	2,489	
	8,653	**657**	**1,290**	**172**	**6**	**3,398**	**16,450**	**30,626**
							Monthly Average	5,104

Based on Early EMAR Spend downs

The percentage change in HCB services provided will be calculated based on the number of persons serviced statewide in 2007 and 2008.

Ongoing activities and accomplishments of the Committee, educational resources made available to the public, as well as, rebalancing efforts enhanced, improved or implemented based on recommendations by the Committee will be reported quarterly to the grantor.

Benchmark #5: North Dakota will implement a crisis response process to support:

- Individuals who have transitioned from a nursing facility to the community by 6/30/2008
- Individuals currently in the community who might otherwise require institutional services but for the availability of this service by 1/1/2010

As part of the quality management system, ND will implement a crisis response process by July of 2008 to support individuals who have transitioned from an institution to the community and offer the same service state wide by 2010 to support those currently in the community who might otherwise require institutional services but for the availability of this process.

Currently county HCBS case management staff do not have a formalized team process in place to address crisis situations for persons receiving HCBS or Medicaid State Plan services. Questions or concerns are now directed to a HCBS Program Administrator of the Medical Services Division of the Department of Human Service. These consultations are currently managed by phone. Calls are received from the HCBS case mangers on a daily basis to address routine questions or needs. Calls that could be characterized as a crisis call are occurring at the rate of two to three times per month at this time.

Based on the informal call data on current call frequency to the HCBS Program Administrators it has been estimated that the development of Individual Crisis Planning Teams to address these crisis situations will likely be necessary two to four times per month.

The Crisis Planning Team process would be a collaborative effort requested by the HCBS Case Manager or the MFP Transition Coordinator for the purpose of addressing the changing needs of the transitioned consumer. The process will involve the development of Individual Crisis Planning teams at those times when reinstitution is likely if alternative supports or services are not made available to the consumer. The crisis planning team will be established at the request of the Transition Coordinator or the HCBS Case Manager and will be coordinated by the requesting team member. The team will be responsible for identifying the specific support needs that are not adequately being met, evaluating alternative services or funding sources, assessing and arranging for additional training to community personnel to address the specific needs of the consumer to promote success in their community setting.

Membership of these planning teams will include the consumer/legal representative as they are willing to participate, the HCBS Case Manager, the Transition Coordinator, Medical Services-HCBS Program Manager, MFP Grant Program Manager, Qualified Service Providers as appropriate, and other agencies or services as the consumer's support needs dictate. Timely interventions by the Crisis Planning Team will result in supporting continued community living.

The Crisis Response Teams will be individually managed and directed by the consumer's case manager or Transition Coordinator requesting assistance. These teams will involve a HCBS Program Administrator from the Department of Human Services Medical Services Division and/or the MFP Program Administrator. The consumer will be requested to actively participate in the team meeting to communicate their specific goals and needs related to continued community living and in support service plan development.

The teams will meet in person, by telephone, or through an interactive video network system (polycom) as distance and timeliness requires. The polycom system is available state wide with sites at all eight regional Human Service Centers.

The Crisis Team process will be sustainable as the state will be using current the resources serving the consumer to formulate the teams. The teams will be temporary in nature and not require any ongoing funding to maintain. The process will improve the use of the time and skills of the professionals within the current system to better meet the needs of the consumers.

Number of Individuals Served by Crisis Response Process During MFP Demonstration

	2007 (baseline)	2008	2009	2010	2011
# of Individuals	0	5	6	8	8

SECTION B – DEMONSTRATION IMPLEMENTATION POLICIES AND PROCEDURES

B.1 Participant Recruitment and Enrollment

The ND Outreach/Marketing/Education Operational Protocol will outline the general and population specific efforts that have been or will be utilized to educate potential participants/family members, agency professionals, and the community about the MFP demonstration. Reference is invited to this section B. 3 Outreach/Education/Marketing of the operational protocol for a review of these strategies.

Target Populations

Nursing Facilities:

The ND MFP Demonstration will specifically target persons for transition who are elderly or persons that have a physical disability and have expressed a preference to return to the community as indicated in MDS question Q1a, and are not severely impaired in cognitive skills for decision making as assessed in MDS section B, and do not have a diagnosis of Alzheimer's Disease as listed in MDS section I. Persons with a developmental disability with a Q1a preference to return to the community will also be offered transition assistance from a nursing facility. In addition these persons will need to have been residing in an institutional setting for at least six months, meet level of care requirements, and have been determined to be Medicaid eligible for the thirty day period immediately prior to transition.

The Minimum Data Set (MDS) is a tool used by nursing facilities to assess the needs of their current residents/consumers. ND will utilize this assessment to determine eligibility for MFP participation.

Section Q of the MDS assessment evaluates the residents "DISCHARGE POTENTIAL AND OVERALL STATUS".

- The document specifically asks (Q1a) if the Resident expresses/indicates preference to return to the community and (Q1b) if the Resident has a support person who is positive towards discharge. If the resident/consumer indicates yes to Q1a the current cognitive state would be reviewed to determine eligibility.

The nursing facility professionals responsible for completing the assessment communicate with the individual/consumer in the communication method preferred by the individual to ascertain the individual's preference.

- MDS section B is titled “COGNITIVE PATTERNS” and assess the following issues: “COMATOSE STATE, MEMORY/RECALL ABILITY, COGNITIVE SKILLS FOR DAILY DECISIONMAKING, INDICATORS OF DELIRIUM—PERIODIC DISORDERED THINKING/AWARENESS, CHANGE IN COGNITIVE STATUS”

- If question B.4 COGNITIVE SKILLS FOR DAILY DECISIONMAKING is answered with the response: SEVERELY IMPAIRED—never/rarely made decisions, the person would not be eligible to participate in the MFP grant process. If any other rating is received the person would be eligible for grant participation.

- MDS section I is titled “DISEASE DIAGNOSES” and inquires if the individual has a diagnosis of Alzheimer’s disease (I q). If the assessment indicates the individual has a diagnosis of Alzheimer’s disease they would not be eligible to participate in the MFP Grant.

Nursing Facility Level of Care Screening Criteria

Minimum criteria for nursing facility Level of Care as specified in the North Dakota Administrative Code 75-02-02-09

In determining level of care, the individual must require or meet a minimum of one of the criteria listed in “Section A” **or** two criteria included in “Section B” **or** criteria in “Section C” **or** all the criteria in “Section D”

Section A:

1. Nursing Facility stay is, or is anticipated to be, temporary for receipt of Medicare Part A benefits. Nursing facility stay may be based on this criterion for no more than fourteen (14) days beyond termination of Medicare Part A benefits;

2. The individual is in a comatose state; Date of onset: _____

3. The individual requires use of a ventilator for at least six (6) hours a day;

4. The individual has respiratory problems that require regular treatment, observation or monitoring that can only be provided by or under the direction of a registered nurse (or in the case of a facility which has secured a waiver of the requirements of 42 CFR 483.30(b), a licensed practical nurse) and she/he is incapable of self care;

    a. Problem
    b. Treatment

5. The individual requires constant help at least 60% of the time with at least two (2) of the following Activities of Daily Living (ADL's):

    a. Toileting (process of using toileting equipment and cleansing self)
    b. Eating (process of getting food from receptacle into the body)
    c. Transferring (process of moving to and from bed, chair, toilet)
    d. Locomotion (process of navigating home environment with or without adaptive devices, as appropriate)
    e. Constant help is required if the individual requires a caregiver's continual presence or help, without which the activity would not be completed.

        i. Identify and describe:

6. The individual requires aspiration for maintenance of a clear airway;

    a. Describe Frequency:

7. The individual has dementia, physician diagnosed or supported with corroborative evidence for at least 6 months, and as a result of that dementia, the individual's condition has deteriorated to the point that a structured, professionally staffed environment is needed to monitor, evaluate and accommodate the individual's changing needs.

    a. Describe needs and provide date of onset/initial diagnosis:
    b. Date of Diagnosis:
    c. Needs:

Section B: (If no criteria in section A are met, an applicant or resident is medically eligible for NF level of care if at least two of the following criteria apply):

1. The individual requires administration of a prescribed:
    a. Injectable medication; **or**
    b. Intravenous medication and solutions on a daily basis; **or**
    c. Routine oral medications, eye drops or ointments on a daily basis
    d. List relevant medications:

        i. Medication Dosage:
        ii. Route:
        iii. Date started:

2. The individual has one or more unstable medical conditions requiring specific and individual services on a regular and continuing basis that can only be provided by or under the direction of a registered nurse (or, in the case of a facility which has secured a waiver the requirements of 42 CFR 483.30 (b), a licensed practical nurse). Identify diagnosis and describe services needed:

a. Unstable Medical Diagnosis:
b. Date of instability:
c. Services Required:

3. The individual is determined to have restorative potential and can benefit from restorative nursing or therapy treatments. (e.g., gait training, bowel and bladder training) which are provided at least five (5) days per week. Identify restorative procedures required:
    a. Restorative Services
    b. Frequency Provided

4. The individual needs administration of feedings by:
    a. Nasogastric tube
    b. Jejunostomy
    c. Gastrostomy parenteral route
    d. Other (specify):

5. The individual requires care of:
    a. Decubitus ulcers
    b. Stasis ulcers
    c. Other widespread skin disorders (specify):
    d. Treatment required:

6. The individual requires constant help at least 60% of the time with one (1) of the following:
    a. Toileting (using toileting equipment and cleansing self)
    b. Transferring (moving to/from bed, chair, toilet etc)
    c. Locomotion (navigating home environment with/without adaptive devices)
    d. Eating (getting food from receptacle into the body)
    e. Describe Assistance Needed:

Section C: If **no** criteria in Section A and/or insufficient criteria in Section B was met, an applicant/resident who applies to or resides in a nursing facility for non-geriatric individuals with physical disabilities may demonstrate that nursing facility level of care is necessary if:

1. The individual is determined to have restorative potential. Describe:

Section D: If no criteria in Section A, Section B or Section C are met, the individual who applies for care in a nursing facility may demonstrate that a nursing level of care is medically necessary if:

1. The individual has an acquired brain injury which includes:
    a. Date:

b. Anoxia
c. Cerebral vascular accident
d. Brain tumor
e. Infection
f. Traumatic Brain Injury;

2. As a result of the brain injury, the individual requires direct supervision at least eight (8) hours a day.

    a. Describe Supervision
    b. Who Provides

Level of Care Appeal Process

The individual or legal representative may appeal the Level of Care eligibility decision within 30 days of the date of this notification. If the request for a hearing is received by the appeals supervisor within 10 days from the date of this notice, the funding for services may continue until an appeal decision is reached. However, all costs for services received must be paid back if the appeal is upheld. The individual may represent him/herself in an appeal hearing or may use a legal counsel, relative, friend, or other spokesperson. The reason for the appeal must be submitted in writing to:

Appeals Supervisor
North Dakota Department of Human Services
600 East Boulevard Avenue
Bismarck, North Dakota 58505-0250

75-01-03-08.2 – Notice of preadmission screening and resident review determinations.

1. An individual dissatis□ed with an adverse determination made with regard to the preadmission screening and resident review requirements of 42 U.S.C. 1396r(e)(7)(A) or (B) may request a fair hearing in review of that determination.

2. The right to request a fair hearing under subsection 1 arises upon receipt of a notice under subsection 3.

3. If the department's action in administering preadmission screening and resident review is adverse to an individual, the department shall provide to the individual a written notice which conforms to section 75-01-03-07 and which includes:

    a. A statement of the adverse determination;
    b. The reason for the adverse determination;
    c. The date of the adverse determination; and

d. A statement that 42 U.S.C. 1396r(e)(7) requires the Department to make such determinations.

4. For purposes of this section and sections 75-01-03-07 and 75-01-03-09.2:

   a. "Adverse determination" means a determination made in accordance with 42 U.S.C. 1396r(b)(3)(F) or 42 U.S.C. 1396r(e)(7)(B), through the application of section 75-02-02-09, that the individual does not require the level of services provided by a nursing facility or that the individual does or does not require specialized services, but does not mean a determination, made under 42 CFR 483.128, that an individual is not suspected of having mental illness or mental retardation; and
   b. "Signi□cant change" means:
      i. A signi□cant physical status improvement experienced by a nursing facility resident, such that the resident is more likely to respond to special treatment for that condition or might be considered appropriate for a less restrictive alternative setting;
      ii. The presence of a nursing facility resident's mental illness, mental retardation, or condition related to mental retardation, not identi□ed prior to admission, when it later emerges or is discovered;
      iii. Exhibition of increased symptoms of mental illness or behavioral problems by a nursing facility resident; or
      iv. A circumstance arising if a review resulted in a determination requiring inpatient psychiatric treatment for a nursing facility resident, and an update to that determination is needed to support that individual's admission or readmission to a nursing facility following delivery of psychiatric services.
      v. Preadmission screening and resident review, including determinations of signi□cant change, is undertaken applying professional judgment and standards approved by the department that are consistent with the requirements of 42 CFR part 483, subpart C, and 42 U.S.C. 1396r(f)(8).

Nursing Facility Transition Recruitment and Enrollment Process:

All persons who are eligible for home and community based services and reside in a nursing facility and have expressed a preference to return to the community as indicated in MDS question Q1a, and are not severely impaired in cognitive skills for decision making as assessed in MDS section B, and do not have a diagnosis of Alzheimer's Disease as listed in MDS section I. will be eligible to participate in the ND MFP demonstration. This includes persons eligible for the North Dakota HCBS Waiver for HCBC Services, North Dakota Technology Dependent Waiver, Medically Fragile Children Waiver, MR/DD Waiver, Self-Directed Supports for Families and Self Directed Supports for Adults. All current waiver services are listed to allow for MFP eligibility and services to persons that are elderly, persons with a developmental disability, or persons

with a physical disability. Services received from any one of these programs during participant grant eligibility would be considered a MFP demonstration service and not a waivered service.

The Transition Coordinator staff from the ND Independent Living Centers will be the professionals involved with enrolling MFP participants that reside in a nursing facility. The four centers include the Dakota Center for Independent Living of Bismarck and Dickinson; Independence Inc of Minot and Williston; Options Resource Center for Independent Living of East Grand Forks and Cavalier; and Freedom Resource Center of Fargo and Jamestown. Each of these Centers will be responsible for serving the nursing facilities in their designated service area. Each Center has designated up to three employees to serve as Transition Coordinators.

The Transition Coordinators will be providing MFP brochures and information to nursing facility social services staff to use to make other residents aware of the grant and will be available for presentation to NF Resident Counsels or facility staff. An MFP sign will be displayed in all nursing facilities.

The demonstration project as originally planned was designed to focus nursing facility transition services only in the Fargo and Grand Forks regions of State for the first year of the grant. The MFP nursing facility transition services demonstration services will now be provide Statewide from the beginning of grant implementation.

The ND Department of Human Services, Medical Services Division maintains a Minimum Data Set (MDS) database and this will be used to identify potential grant participants. ND nursing facilities complete a comprehensive MDS assessment quarterly and this information is submitted to the ND Department of Human Services. This assessment updates the Q1a, B4, and Iq questions on a quarterly basis.

The Money Follows the Person(MFP) Program Administrator will access the information contained in the Minimum Data Set (MDS), which is an instrument used in nursing facilities to assess residents. All certified Medicare or Medicaid nursing facilities must complete, record, encode and transmit to CMS the MDS for all residents in the facility. While the MDS was developed to provide consumers with an additional source of information about the quality of nursing home care and to help providers improve quality of care, it is also a tool that could be used to identify and locate nursing facility residents who would like to be served in an alternative setting. The MFP Program Administrator will use the MDS information to identify nursing facility residents who wish to be served in a more home-like setting and to assess which residents are most likely to be successful in transitioning to the community.

The most recent Minimum Data Set (MDS) on file in the ND Department's database will be used to first identify Medicaid individuals who meet the minimum six-month institutional requirement and have expressed a desire to return to the community; and are not severely impaired in cognitive skills for decision making or do not have a diagnosis of Alzheimer's. Once identified, information on all individuals will be forwarded

through the mail by the MFP Grant Program Administrator to both the local Center for Independent Living Nursing Facility Transition Coordinator (TC) and the individual's nursing facility Social Services Director. Once the referral information has been received the Transition Coordinator and the NF Social Services staff will interview the nursing facility consumer/resident together to determine if transitioning is desired by the individual and to assess the potential for transitioning the individual to his or her desired community based on available informal and formal resources and supports available in the community. In addition, any Medicaid eligible individual can self-refer to a Transition Coordinator if they meet the level of care and minimum 6-month occupancy criteria and intend to move to a qualified residence.

The Transition Coordinator is responsible to initiate contact with the NF Social Services representative and to conduct a face-to-face interview with the potential participant and family/legal decision maker the NF Social Services representative to determine the individual's desire to participate in the MFP Grant services. The TC will enlist the nursing facility discharge planning team, appropriate health care professionals, and consumer-identified informal supports to gain additional information to support the viability of a transition to the community.

The Transition Coordinator will be responsible to address the concerns/questions that may be identified by the consumer, a family member/legal guardian, or NF staff member related to the MFP participant's interest in transitioning to the community.

If a nursing facility resident has a developmental disability and is in need of assistance with a transition to the community, a referral will be initiated to the regional human service center for Developmental Disabilities (DD) Case Management services. The TC will work with the DD Case Manager to determine the most appropriate transition assistance delivery system to be employed.

After implementation individuals who are admitted to nursing facilities will be recruited for the MFP demonstration project through a variety of agency groups including:

- Nursing Facility Social Services staff,
- Long Term Care Ombudsman Program staff,
- ND Protection and Advocacy Project Representatives,
- County Social Services Staff and,
- Center for Independent Living Center Transition Coordinators.

The Nursing Facility Social Services staff, Center for Independent Living Transition Coordinators, Long Term Care Ombudsman, ND Protection and Advocacy staff, and County Social Services staff will be provided with MFP specific training related to eligibility, demonstration and supplemental services, consent, rights, and processes by the MFP Program Administrator. (Attachment B.1-E (MFP Power Point and Person Centered Training Information) A Referral Packet Information List and Process Directions (B.1-F) will be prepared for use by Transition Coordinators and NF Social Services staff when meeting with potential MFP demonstration participants to review

service options for transition to the community and to assure that all necessary consent and rights information is reviewed and needed documents are signed. This packet will include the following documents: B.2-A Informed Consent Document; B.2-B Money Follows the Person Rights Document; B.2-C Guardianship Expectation Document; B.1-B MFP Role Matrix ; B.1-C MFP Fact Sheet; B.1-D MFP Brochure; B.5-A Supplemental Services Request Form, and an Assistive Technology Assessment form from the IPAT agency.

A MFP participant who is re-institutionalized for a period of time greater than 30 days is deemed disenrolled from the MFP program. However, a disenrolled individual may re-enroll in the program without re-establishing the 6-month institutional residency requirement.

A former participant may re-enroll in the MFP program after first undergoing re-evaluation (Attachment B.8-A Transition Assessment) by their Transition Coordinator/discharge planning team and after development of a current Independent Living Plan (ILP). (Attachments B.8-B Independent Living Plan which includes Risk Mitigation Plan/24 hour Backup; B.8-H Risk Assessment and Mitigation Policy and NF plan form; B.8- I 24-backup Planning Policy and Back-up Plan).

Once the individual is found appropriate for waiver services, the consumer and planning team will develop and/or update their Independent Living Plan so that it addresses the change in the status of the MFP participant and any necessary support service needs in the community. This planning process will involve the review and update of the risk mitigation and 24 hour backup plans to assure that they continue to address the participant's current need for support. As long as a former MFP participant meets Medicaid waiver eligibility criteria, the participant continues to be eligible for MFP services at the enhanced Federal Medical Assistance Percentage (FMAP) match.

See Attachments:

B.1-A MFP Referral; B.1-B MFP Role Matrix; B.1-C MFP Fact Sheet; B.1-D MFP Brochure; B.1-E: Education PowerPoint/Person Centered Planning Information; B.1.F: Referral Packet Information B.2-A Informed Consent Document; B.2-B Money Follows the Person Rights Document; B.2-C Guardianship Expectation Document; B.8-A Transition Assessment; B.8-B Independent Living Plan which includes Risk Mitigation Plan/24 hour Backup; B.8-H Risk Assessment and Mitigation Policy and NF plan form; B.8- I 24-backup Planning Policy and Back-up Plan

North Dakota Developmental Center and Community Intermediate Care Facilities for Persons with Mental Retardation:

The MFP Demonstration will specifically target persons for transition that reside at the ND Developmental Center or a community ICF/MR, have a diagnosis of a developmental disability and desire to return to the community. In addition these persons will need to have been residing in an institutional setting for at least six months, meet ICF/MR level of care requirements, and have been determined to be Medicaid eligible for the thirty day period immediately prior to transition. MFP participants will be involved with MFP demonstration services in the community. These will be the same services the participant would normally have received through one of the developmental disabilities waivered services.

ICF/MR Level of Care (LOC) requirements are as follows:

The Progress Assessment Review (PAR) (Attachment B.8-D) is the comprehensive assessment used to evaluate an individual's support and service needs. There are two PAR formats: one for children birth to three and one for individuals three and older. The PAR is also the evaluation used to determine whether an individual meets the basic requirements for ICF/MR level of care.

The Progress Assessment Review (PAR) is an individual assessment that describes the level of supports needed by an individual 3 years of age and older in the following areas: residential, day services, motor skills, independent living, social, cognitive, communications, adaptive skills, behavior, medical, psychiatric and legal. The PAR also includes a section that lists the individual's diagnoses on Axis I regarding chronic or recurrent clinical disorders, Axis II regarding chronic or recurrent personality disorder or mental retardation and Axis III regarding chronic or recurrent medical conditions from the DSM IV. The D.D. Case Manager completes the PAR with input from the consumer and/or family and provider support staff.

The D.D. Case Manager completes the PAR either at the time of intake or shortly thereafter, prior to the eligibility determination for developmental disabilities case management services. Certain areas derived from the PAR will provide the MFP Regional Eligibility Team with information regarding limitations in the seven major life activities during the process of the eligibility determination.

- Self care
- Learning
- Receptive and Expressive Language
- Mobility
- Self Direction
- Capacity for Independent Living
- Economic Self Sufficiency

The Child PAR (for children birth to three years of age) addresses:

Engagement/persistence, Reasoning/Problem Solving, Listening/Understanding, Speaking/Communicating, Phonological Awareness, Print Awareness, Fine Motor, Gross Motor, Hygiene/Nutrition, Cooperation/Self Control, Social Relationships, Arts/Movement/Music, numbers/Operations, Patterns/Measurement, Matter/ Force/ Energy, and Family Roles/Relationships.

Once the PAR is completed, an indicator is derived from the scores in the assessment that determines whether an individual meets the basic criteria for the ICF/MR level of care. The indicator is referred to as the "HCBS indicator". If the HCBS is "Y" (Yes), the individual meets the basic criteria; "N" (No), the basic criteria is not met and the individual cannot be screened; "P" (Professional Judgment), the case manager must apply the criterion outlined in State policy DDD-PI-090 to determine if the individual can be screened.

If the individual is eligible for DD Case Management Services, the case manager will assist the individual and/or their legal decision-maker to identify desired outcomes and the services that can assist them in achieving the outcomes. If the individual chooses to receive a waiver service within the next 30 days, and meets the ICF/MR level of care, the case manager will complete the ICF/MR level of Care screening document.

The **Case Action Form** documents an individual's need for an ICF/MR level of care. The information contained in the Case Action Form is entered into the MMIS (Medicaid Management Information System) payment system. The Case Action form, in conjunction with the Individual Service Plan, authorizes reimbursement for Title XIX Medicaid funds for ICF/MR and DD Waiver Home and Community Based waiver services.

The Progress Assessment Review (PAR) and ICF/MR level of care screening (Case Action Form) must be updated at least annually. System generated alerts within ASSIST inform the case manager of when the annual PAR and LOC are due. The individual's screening status/LOC should also be reviewed, and updated if necessary; each time an individual starts or terminates a DD service to ensure the screening status (LOC) is correct. If the Case Action Form is not current and accurate, the Medicaid payment is suspended.

Review of ICF/MR Level of Care Decisions

The PAR (which is the assessment for Level of Care) is completed annually. Based on a formula the results indicate screening categories. A sample of all PARs and ICF/MR level of care screenings are reviewed and compared during the human service center licensure process. If errors are discovered the regional human service center must develop a plan of correction and a follow up sample will be examined.

If an individual was incorrectly screened the case manager will work with the individual to find alternative funding sources to meet their support needs

North Dakota Developmental Center and Community Based Intermediate Care Facilities for the Mentally Retarded Transition Recruitment and Enrollment Process:

All persons who are eligible for home and community based services and reside at the ND Developmental Center (NDDC) or who reside in a community based ICF/MR in ND and meets MFP eligibility requirements will be eligible to participate in the ND MFP demonstration. This includes persons eligible for the MR/DD Waiver, Self Directed supports for Families Waiver, Self Directed Supports for Adults Waiver and the Medically Fragile Children Waiver.

The waivers require that the participant meet ICF/MR level of care requirements as well as waiver specific functional eligibility requirements. Once it is determined that an individual meets MFP specific criteria an assessment is completed by the DD Case Manager to determine waiver specific eligibility based on the individual service needs of the participant. (Attachment B.8-D Developmental Disabilities Progress Assessment Review (PAR)

The ND MFP demonstration will be implemented statewide for this population group as the community service delivery infrastructure is generally well established.

North Dakota has developed a discharge-planning model to identify eligible consumers at the state operated institution (North Dakota Developmental Center – a.k.a. NDDC) for persons with developmental disabilities. The discharge-planning model, named the Residential Decision Profile (RDP) (Attachment B.8-E), is based upon principles from the U. S. Supreme Court Olmstead Decision. In general, no person is under commitment to the Developmental Center, as residence is a voluntary decision of the person and/or legal decision-maker (such as guardian, which includes annual judicial oversight). The preferences of the person and recommendations of state professionals (Developmental Disabilities Case Manager (DDCM) and NDDC Staff) are measured by the RDP with discharge planning emphasized for those with most agreement. Although the preferences are updated every year, each person is assured the RDP can be modified at any time during the year if there is a change.

For Medicaid eligible individuals, residing in Developmental Center ICF/MRs, the service and community preferences of the person, and/or their authorized representative, DDCM and NDDC Staff help guide the priority for discharge planning from the Developmental Center (DC) and are recorded in the Residential Decision Profile as:

A) The Individual:

1) The RDP is finalized he/she clearly wants to leave NDDC

2) Generally appears to want to leave NDDC, but the decision may not be firm because it varies, is not completely clear, or there are some reservations
3) Unclear which way the person prefers
4) Generally appears to want to stay at NDDC, but the decision may not be firm because it varies, is not completely clear, or there are some reservations
5) Clearly wants to stay at NDDC

B) Guardian, Court, or other legal decision-making authority

1) Clearly wants the individual to leave NDDC
2) Generally wants the individual to leave NDDC, but the decision may not be firm because it varies, is not completely clear, or there are reservations
3) Unclear which way the legal decision-maker prefers, or NOT Applicable
4) Generally wants the individual to stay at NDDC, but the decision may not be firm because it varies, is not completely clear, or there are reservations
5) Clearly wants the individual to stay at NDDC

C) NDDC Staff (note: SP Team NDDC staff perspective) on services unique to NDDC

1) Clearly believes the individual does NOT need NDDC services
2) Generally appears NOT to need NDDC services, but the decision may not be firm because it varies or there are some reservations
3) Unclear to the NDDC staff
4) Generally appears to NEED NDDC services, but the decision may not be firm because it varies or there are some reservations
5) Clearly NEEDS the NDDC services

D) DD Regional Program Administrator/Case Management perspective on services known to be available in the region or elsewhere in the state (not based upon openings):

1) Clearly able to meet individual's needs
2) Generally appears that the services are able to meet individual's needs, but the decision may not be firm because it varies or there are some reservations
3) Unclear to regional staff as to the availability of such services
4) Generally appears that the services are NOT able to meet individual's needs, but the decision may not be firm because it varies or there are some reservations
5) Clearly unable to meet the individual's need

The statements listed above are selected by each party before or during the Support Plan meeting, or on their behalf by the team based upon the best understanding the team has of each person (group) perspective. The decision reflects the current opinion, based upon the most current information available to them, and relate to the person

now and in the foreseeable future. Each perspective may only choose from the answers available, and may only choose one – however, each person (group) may add to the comments.

From a "scoring" perspective, the number of each selected answer is the "weight" given that answer and a total score may be calculated for the individual. To provide agency planning, the scores would range from 4 (all 1's) (clearly awaiting a place to move to) to 20 (all 5's) (clearly exceeding the services of the region and state providers to meet the individual's needs) and anywhere in between. This provides a ranking of people planning to leave NDDC for private provider opportunities in the communities of choice. This process also highlights areas of disagreement, confusion, and focus planning.

A RDP total score of 12 or less has sufficient agreement that formal discharge planning will be initiated by the NDDC Support Team. At that time consumers and/or their legal decision maker will be made aware of the MFP demonstration services available and will be provided with the opportunity to make an informed decision about participation in the demonstration. The NDDC social worker and/or Program Coordinator will be responsible for reviewing the MFP informed consent document (Attachment B.2-A), MFP Brochure, (Attachment B.1-D), Role Matrix (Attachment B.1-B), the MFP Fact Sheet (Attachment B.1-C) documents with the consumer and/or their legal decision maker at that time.

The NDDC Social Worker and Program Coordination staff will be provided with MFP specific training related to eligibility, services, consent, rights, and processes (Attachment B.1-E) by the MFP Program Administrator. An information packet will be prepared for use by each Support Team Program Coordinator/social worker when offering MFP demonstration services for transition to the community to assure that all necessary consent and rights information is reviewed and needed documents are signed (Attachment B.1-F).

For individuals residing in small, community-based intermediate care facilities for the mentally retarded, North Dakota utilizes a referral process whereby consumers and families, working with their DD case manager, have an opportunity to make informed decisions regarding the provision of services and supports, choice of service providers, and choice of intermediate care facility for the mentally retarded (ICF/MR) or home and community-based (HCBS) waiver services. This may include providing the consumer and/or family with questions they may wish to ask potential providers, and furnish provider/agency brochures describing available services and supports. The DD case manager will offer to arrange tours and visits to provider agencies and will accompany the consumer and family on these visits. It may also involve formal referral or case management networking to link consumers with community resources that are not providers of traditional DD services. This process is also utilized with individuals residing at the Developmental Center that are considering community placement.

North Dakota will use existing information technology systems to identify MFP participant demographic, financial and case plan information. This information includes

Medical Assistance Eligibility, Level of Care determination, and length of time in each level of service including at the ICF/MR level of care. The existing technology system, Achieving Support System Integration through Services and Technology (ASSIST), addresses supports coordinated through developmental disabilities case management. The objective of ASSIST is to be a consumer driven, outcome oriented, accountable, and integrated business solution.

Through ASSIST's case management processes, case plans are developed and managed that stress outcomes, goals, and objectives to meet consumer and family needs to work toward providing the most efficient and effective developmental disability services for North Dakota citizens.

> Individual ICF/MR planning teams, including the DDCM, will review the service needs of all consumers during their annual or other planning meetings based on the community provider specific assessments completed in preparation for those meetings. If the consumer and/or their legal decision maker, the DDCM, and the community provider recommend transition to an alternative setting in the community the consumer will be informed of alternatives available under the demonstration grant and that the individual is given choices of services and community residences which must be agreed to by the individual in the individual's transition plan which identifies the demonstration services to be furnished, the individual's choice of providers, informal supports, and residence. If the consumer wishes to participate in the MFP demonstration the DDCM will specifically review and have the consumer/legal decision maker sign the MFP consent document (Attachment B.2-A) and will provide and explain the MFP Brochure (Attachment B.1-D) and the MFP rights documents(Attachment B.2-B), Role Matrix (Attachment B.1-B) MFP Fact Sheet (B.1-C), Guardianship Expectations (Attachment B.2-C), and assist in the development of the transition plan(Attachments B.8-H Risk Assessment and Mitigation Policy and DD plan form; B.8-I 24-hour Backup Planning Policy and Back-up Plan)

The Developmental Center Staff, DD Case Managers, and community provider program coordination staff will be provided with MFP specific training related to eligibility, services, consent, rights, and processes by the MFP Program Administrator. (Attachment B.1-E) An information packet (Attachment B.1-F) will be prepared for use by DD Case Manager when meeting with potential MFP demonstration participants to review service options for transition to the community and to assure that all necessary consent and rights information is reviewed and needed documents are signed.

An MFP participant who is re-institutionalized for a period of time greater than 30 days is deemed disenrolled from the MFP program. However, a disenrolled individual may re-enroll in the program without re-establishing the 6-month institutional residency requirement.

A former participant may re-enroll in the MFP program after first undergoing re-evaluation by their support/planning team and after development of a new and current Transition/Individual Service Plan (ISP) (Attachment B.8- C. Once the individual is found appropriate for waiver services, the planning team and DD Case manager will develop a transition plan (Attachments B.8-H Risk Assessment and Mitigation Policy and DD plan form; B.8- I 24-Backup Planning Policy and Back-up Plan and ISP that addresses the change in the status of the MFP participant and necessary supports in the community. This planning process will involve the review and update of the risk mitigation and 24 hour backup plans to assure that they continue to address the participant's current need for support. As long as a former MFP participant meets Medicaid waiver eligibility criteria, the participant continues to be eligible for MFP services at the enhanced Federal Medical Assistance Percentage (FMAP) match.

See Attachments:

B.1-B MFP Role Matrix; B.1-C MFP Fact Sheet; B.1-D MFP Brochure; B.2-A Informed Consent Document; B.2-B Money Follows the Person Rights Document; B.2-C Guardianship Expectation Document; B.8- C Developmental Disabilities Individual Service Plan; B.8-D Developmental Disabilities Progress Assessment Review (PAR); B.8-E Resident Decision Profile; B.8-H Risk Assessment and Mitigation Policy and NF and DD form; B.8- I 24-Backup Planning Policy and Back-up Plan

B.1-E Education PowerPoint and B.1-F Referral Packet Information List

B.2 Informed Consent and Guardianship

Procedures for Providing Informed Consent

As a first step in ensuring that participants have informed consent, participants and/or their legal representatives will be provided with ample information concerning the MFP project and ongoing opportunity for questions. North Dakota will require that all individuals participating in the MFP Demonstration or their Legally Authorized Representative (LAR) -- i.e., parent, guardian, or managing conservator of a minor individual, or a guardian of an adult -- be informed of all their rights (Appendix B.2-B) and options for long-term services and supports and that participation is voluntary. This includes acceptance of services and the consent to participate in the evaluation component of the grant. The Informed Consent Form (Appendix B.2-A) will be signed only by the individual being transitioned or those who have legal authorization to act in the individual's behalf.

The Transition Coordinator or DD Case Manger will determine if the participant has a guardian or an active Durable Power of Attorney (DPOA). The Coordinator or Case Manager will obtain a copy of the legal document(s), review it/them and have an understanding of the extent of the surrogate decision-making power that exists. This information will be garnered from a review of the facility records once consumer consent is obtained. For participants with a guardian or other legal representative, both the participant and the legal guardian will be involved in providing information and in the transition planning process.

Transition Coordination, Developmental Disabilities Case Management, or the Developmental Center Social Work staff will secure the appropriate signatures on the Informed Consent form (Appendix B.2-A) which indicates that the participant has been informed and is voluntarily choosing to participate in the MFP Demonstration without coercion.

Awareness of Transition Process/Knowledge of the Services and Supports

Section B.1 Participant Recruitment and Enrollment of the MFP Operational Protocol identifies the transition process and information provided to the consumer and/or their Legally Authorized Representative for nursing facility and ICFs/MR and Developmental Center transitions.

Consumers will be identified for grant participation in several ways including but not limited to MDS assessments, nursing facility referral, referral from an advocacy representative, family referral, community provider referral, case manager referral, and self-referral. In most cases, the initial contact for a nursing facility transition will be through the Transition Coordinator and the nursing facility social worker who will provide information on the transition process. The Transition Coordinator would than conduct an

assessment of the individual's transition needs and work with the nursing facility discharge team to assist with transition.

Individuals living in an ICF/MR facility or at the Developmental Center are not likely to identify themselves for grant participation due to the nature of their disability. Developmental Center staff or DD Case Management staff will be the most likely to make the initial referral for services. At the Developmental Center the individual support plan team using the Residential Decision Making Process (RDMP) and RDP (Attachment B.8-E Resident Decision Profile) is the typical first step in assessing the desire to move into a community setting and the increasing awareness of the transition process. At a community ICF/MR the DD Case Manger and the consumers planning team will communicate MFP information when community transitioning is being planned. It is during this process that the individual's desires and choices for their preferred living arrangement are determined and information is gathered to effect a successful transition. The Developmental Center Social Worker and/or the DD Case Manger in cooperation with the community provider team will further discuss the transition process, assist in locating the preferred living arrangement, and develop a transition plan that takes into consideration the individual's need and choice for services and supports.

Information about Rights and Responsibilities

Informed consent under this MFP Demonstration will include two components: 1) the acceptance of services and; 2) the consent to participate in the evaluation component of the project.

The consent for waiver services will follow current 1915(c) waiver practices (as dictated by CMS) and will be obtained during the support planning phase of the transition but prior to the delivery of home and community-based services. Risks of receiving certain services, the range of services that are available, and any restrictions on amount, duration and scope because of cost caps will be included in the informed consent process. Additional supports necessary to carry out the service plan will be fully explained to the prospective MFP Demonstration participant or representative, particularly with regard to self-directed services and supports.

The Informed Consent form (Attachment B.2-A Informed Consent Document) will include the provision that participation in the MFP Demonstration is voluntary and protects project-related information that identifies individuals. The document will state that the information is confidential and may not be disclosed directly or indirectly, except for purposes directly related with the conduct of the project. The document will also indicate that the state will obtain written consent of the individual prior to disclosure of individual level information.

Finally, the Informed Consent form advises the individual that they can withdraw from the project at anytime, that the 24-hour nurse call service will only be available while

they are an active MFP participant, that the MFP Demonstration services are available for one year, and that their support services will continue after the MFP Demonstration period through an existing Medicaid 1915c waiver as long as they continue to meet the eligibility requirements for the program.

Waiver Appeal Process

The waiver appeal process is outlined Section B.6 Consumer Supports

Guardianship Alternatives

Guardianship is considered the least favorable alternative to independent decision making by a consumer. The least restrictive alternative for decision making support is most preferred. Alternatives that are most commonly considered include payee/fiduciary services to manage finances, Health Care Directives, Power of Attorney arrangements for the management of finance or property, Durable Power of Attorney arrangements to manage finances, property, or medical decisions, and/or conservatorship to manage finances. Limited guardianship is also considered more favorable than full guardianship when that is deemed appropriate by the court.

Guardian Relationships

North Dakota Century Code chapter 30.1-28 allows a court to establish a guardianship of a person lacking decision making capacity. After court order, guardianship continues until the death of the guardian or the ward, or the guardian resigns. The court may terminate the guardianship before then, and can appoint a replacement (successor) guardian. Sometimes when the ward is a spouse or child, the guardian can name a successor guardian in the guardian's will. The guardian must file an annual report with the court. The guardian is responsible for the ward's care, comfort, and maintenance, and any training, education, or habilitative services that are appropriate. The guardian must care for the ward's property. The court may give the guardian partial or complete decision making authority in the areas of residential, educational, medical, legal, vocational, and financial decision-making. No matter what powers the court grants the guardian, the guardian must maximize the ward's involvement in decision making. The guardian may only intervene in the ward's life to the extent necessary to protect the ward. If possible, the guardian should act as they believe the ward would act if the ward had full knowledge and decision-making capacity. A guardian always needs a court order for the ward's psychosurgery, abortion, sterilization, or experimental treatment. Unless the court orders otherwise, the ward retains the rights to vote, marry, divorce, apply for a driver's license, or testify in legal proceedings**.**

MFP Participant Welfare

A review of a MFP participant's contact with their guardian six months prior to MFP participation will be completed by the Transition Coordinator or DD Case Manger/DC Social Worker. The nature of this contact will be reviewed based on the guardian's response to the need of the ward. Nursing facilities, community ICF/MR facilities, and the Developmental Center professionals all document guardian contact with potential MFP participants and have firsthand knowledge of this contact. It will be expected that guardians have demonstrated active involvement related to the health and welfare needs of the MFP participate.

North Dakota guardianship laws and guidelines do not identify a specific frequency of visits that a guardian or legal representative must abide by in order to meet the responsibilities owed to their ward. For the MFP project, however, the frequency of guardianship interaction is ensured, through the care planning requirements that are established in the HCBC waivers. The ND MR/DD Waiver requires the development of an Individual Service Plan (Plan of Care) Attachment B.8- C Developmental Disabilities Individual Service Plan) with the involvement of the Service Coordinator (DD Case Manager), with input from the individual, his/her guardian, family and friends. The services outlined in the Individual Service Plan are tailored specifically to the interests, needs, and competencies of each individual. The Service Plan reflects the choices made by the individual and or guardian and becomes effective only after receiving individual or legal guardian approval. The service agreement is monitored and assessed and any change or additional service needs again require participant and legal guardian involvement and agreement.

The HCBS waiver provides similar safeguards and guidelines for ongoing participant and guardian involvement for development of Care Plans. This includes the development of a Plan of Care prior to receipt of Home and Community Based Services and ongoing review of care after transition that will involve the participant and their legal guardian.

MFP Guardianship Requirements and Interactions

If a public guardian has been appointed for a prospective MFP Demonstration participant, DD Case Manager, Developmental Center Social Worker, or the Transition Coordinator must make contact with that guardian to explain the choices of the prospective MFP participant, key features of the MFP Demonstration program, and various long-term services and support options that are available to the individual.

Guardians of MFP participants will be provided MFP guardian expectations document (B.2-C) outlining the standards that they will be expected to follow in their interaction with the MFP participants. As a project requirement, the Transition Coordinators or DD Case Manager/DC Social Worker will engage in a minimum of one contact with the participant and their ward prior to any transition being implemented. A contact will serve

to maximize the information sharing and assessment. The Transition Coordinator or DD Case Manager will also follow up with both the participant and their legal guardian post-transition to ensure that the individual has successfully transitioned to community living. The Transition Coordinator or the DD Case Manger/DC Social Worker will document these contacts and share information with the MFP Grant Program Administrator wherever appropriate.

See Attachments:

B.2-A Informed Consent Document; B.2-B Money Follows the Person Rights Document; B.2-C Guardianship Expectation Document; B.8- C Developmental Disabilities Individual Service Plan

B.3 Outreach, Marketing and Education

The primary types of media to be used for MFP outreach, marketing and education will be brochures, electronic media, MFP Grant Program Administrator presentations, newsletter communication, and other written training materials.

MFP Brochure

The State of North Dakota will utilize the MFP brochure as one method to market MFP Demonstration Grant Services and to provide outreach and education to prospective consumers, family members, professionals, and the general public. The MFP Stakeholder Committee has developed the MFP brochure in English and large print versions. The MFP brochure will be available in Spanish and translated into other alternative languages as the need is identified. The Brochure will include information on the purpose/mission of the MFP grant; grant eligibility criteria; four primary objects of the grant; contact numbers; and website information.

The MFP informational brochure is targeted to:

- Potential Enrollees (Consumers)
- Family Members/ Decision Makers/Legal Decision Makers
- Service Providers
  - Families of children appropriate for HCBC services
  - Hospital Discharge Planners
  - Outreach Workers
  - Home and Community Based Case Managers
  - Public Health Offices
  - Parish Nurses
  - Human Services Center Personal
  - Home Health Agencies
  - Senior Centers
  - DME Venders
  - Senior Centers
  - Hospitals and Clinics
  - Nursing Facilities

A Money Follows the Person Fact Sheet will be prepared for Center for Independent Living staff, Stakeholder Committee Members, DD Case Managers, HCBS Case Managers, LTC Social Services Staff, the MFP Grant Program Administrator, LTC Ombudsman Staff, Protection and Advocacy Staff and other professionals to use in conjunction with the MFP Brochure to educate consumers, family members, and other professionals about MFP services, eligibility, and related referral process.

See Attachments B.1-C and B.1-D

Electronic Media

The fully accessible ND MFP Website provides an overview of the demonstration services and supplemental services available during the demonstration period outlines MFP eligibility criteria, lists referral contact information, and Stakeholder Committee and workgroup minutes and meeting schedules. The Website will be listed on the MFP brochure to encourage a more in-depth review of MFP Grant referral and contact information. http://www.nd.gov/dhs/info/pubs/mfp.html

The ND Aging and Disabilities Link is maintained by the North Dakota Department of Human Services' Aging Services Division. The link is a one-stop connection to information about services that enhance independence, assure quality of life, and meet the unique needs of seniors and people with disabilities living in North Dakota and other states. The link will include information about MFP Demonstration Services, referral processes, and contacts. The Link will be used by the Aging and Disabilities Resource Center staff to provide MFP specific information.
http://www.nd.gov/dhs/onlineserv/ndseniorinfoline/index.aspx

Newsletters

Quarterly MFP information will provided for the quarterly Home and Community Based Services newsletter that is targeted to HCBS case managers and other County Social Services professionals.

Quarterly MFP information will be provided for the Regional Aging Services Newsletter. This newsletter audience includes county Social Services Directors and HCBS Case Mangers, OAA Outreach Workers, Senior Centers, and Regional Aging Council members.

MFP information will be provided for the Long Term Care Social Workers of ND Association Newsletter.

MFP information will be provided to the ND Association of Community Providers for their newsletter.

MFP information will be provided to the Protection and Advocacy Project and Ombudsman programs for inclusion in their newsletter.

Outreach/Education

MFP training and educational forums and other types of outreach will be scheduled and provided to HCBS Case Managers, Aging and Disabilities Resource Link staff, LTC Ombudsman staff, hospital discharge planners, Nursing Facility Social Services Staff,

Nursing Facility Administrators, Protection and Advocacy staff, etc. including the strategic methods outlined below:

- MFP information booth at Long Term Care Conventions
- Provide written MFP information to Nursing Facility Administrators
- Provide training to HCBS Case Managers at regional meetings and annual training.
- Provide informational packets for use by DD Case Manager when enrolling MFP participants
- Provide informational packets for use by Long Term Care Social Services staff when discussing MFP with potential participants and their family members
- Provide training to Long Term Care Social Services staff during association membership meeting or annual training
- Provide MFP information to Regional Councils on Aging , Governors' Commission on Aging, Forum on Aging, and other senior groups like the Senior Sensation and Graying of North Dakota
- Developmental Center program staff will be provided with an overview of the MFP grant, transition services available, supplemental services options, eligibility requirements, and referral processes
- Provide MFP information to Senior Center staff/ outreach workers
- Provide MFP information to Long Term Care Ombudsman and Volunteer Ombudsman at annual training session
- Provide MFP information to members of the ND Association of Community Facilities serving persons with developmental disabilities
- Provide MFP information to ND Advocacy Groups including ND Association of Disabilities, ND Disabilities Advocates Consortium, ND Protection and Advocacy, AARP, IPAT, Center for Persons with Disabilities
- Provide Information to Staff of Centers for Independent Living
- Review MFP services and referral processes with Aging and Disabilities, Resource Link staff and ADRC staff when developed
- Continue MFP grant education with ND Housing providers and initiate contact with all public housing authorities directors related to the needs of MFP participants
- Provide Regional Aging Service Program Administrators with information related to MFP services and referral process options.
- Stakeholder Committee Member verbal communication to their organization
- Provide an MFP Grant poster to nursing facilities and ICF/MRs to make consumers aware of the grant.
- Provide ongoing outreach to the ND Indian Reservation and Tribal communities with the assistance and support of the DHS Tribal Liaison. This will include continued invitations to participate on the MFP Stakeholder Committee, continued DHS involvement with Tribal planning groups, and MFP participant specific outreach by Transition Coordinators or DD Case Manager on a case by case basis.

Pre-implementation Outreach /Marketing/ Education Activity

- Long Term Care Association Administrators, Nurses, and Social Service Staff were provided with MFP training at six separate regional meetings. Training included a review of the Transition Coordination demonstration service and supplemental services, eligibility requirements, and referral process.

- Adult HCBS Committee was provided with MFP training related to the Transition Coordination demonstration service and supplemental services, eligibility requirements, and referral process.

- Region V and Region VIII Councils on Aging were provided with training related to the MFP demonstration services, supplemental services, eligibility requirements, and referral processes.

- ND Disabilities Advocates Consortium

- ND Protection and Advocacy agency state advocates were provided with a full review of the MFP grant including service options, eligibility, and referral processes.

- The ND Community Facility Providers Board members were provided with a full review of the grant services as they pertain to services for persons with a developmental disability.

- The IPAT consortium was provided with a review of the MFP grant, demonstration services, eligibility requirements, and referral processes.

- County Social Services Directors were provided with an overview of the MFP grant services, eligibility requirements, and referral processes.

- Grand Forks County Vulnerable Adults Committee including housing providers, DD providers, and HCBS providers were provided with information about the MFP grant demonstration and supplemental services, eligibility requirements, and referral processes.

B.4 Stakeholder Involvement

The North Dakota Money Follows the Person Stakeholder Committee was established on November 20, 2007 for the purpose of providing ongoing oversight and/or advice on State policy changes to achieve rebalancing, monitoring grant implementation progress, monitoring achievement of grant benchmarks, recommending ways to improve program design or implementation, participating in the design of the operational protocol (OP), and monitoring its implementation throughout the demonstration period. Active stakeholder involvement is considered vital to the success of the implementation of the Money Follows the Person Rebalancing Demonstration Grant.

The Stakeholders Committee is focused on identifying and implementing strategies that will assist North Dakota to achieve the four primary objectives of the MFP Demonstration Grant with respect to institutional and home and community-based long-term care services under State Medicaid programs to include:

1. Rebalancing

   Increase the use of home and community based, rather than institutional, long-term care services

2. Money Follows the Person

   Eliminate barriers or mechanisms, whether in the State law, the State Medicaid plan, the State budget, or otherwise, that prevent or restrict the flexible use of Medicaid funds to enable Medicaid-eligible individuals to receive support for appropriate and necessary long-term services in the settings of their choice.

3. Continuity of Service

   Increase the ability of the State Medicaid program to assure continued provision of home and community-based long-term care services to eligible individuals who choose to transition from an institutional to a community setting.

4. Quality Assurance and Quality Improvement

   Ensure that procedures are in place (at least comparable to those required under the qualified HCB program) to provide quality assurance for eligible individuals receiving Medicaid home and community-based long-term care services, and to provide for continuous quality improvement in such services.

Consumer participation in the MFP Stakeholder Committee is critical to supporting long term successful system changes. ND has worked with the ND Protection and Advocacy and the Centers for Independent Living to support consumer involvement. Consumers have taken an active role in both the workgroups and the Stakeholder Committee offing significant insight and active participation in decision making and program design

suggestions. Additional Consumers will be invited to participate in the workgroups and the Stakeholder Committee as they volunteer or are identified throughout the term of the Demonstration.

To encourage stakeholder involvement arrangements have been made to support participation in the stakeholder meeting through payment of travel expenses for attending members. Members are provided with a travel voucher to complete after each meeting for payment of the expenses that are related to participation. In addition consumers that participate in meetings are reimbursed for travel, lodging, meals, and personal care assistance expenses. The use of interactive technology is being employed to allow distant stakeholders to participate in workgroups.

Membership

The Stakeholder Committee includes direct consumers and/or their family members, Advocacy Groups, Providers and provider association representatives, State agency staff, housing agency representatives, and a representative of Governor's office. The Committee specifically includes the following members:

Consumers and/or their family members and Advocacy Groups:
Four Consumers/ one family member, ND Protection and Advocacy, ND Long Term Care Ombudsman, The ARC of ND, Interagency Program for Assistive Technology (IPAT), AARP, NDAD, ND Centers for Independent Living, NDDAC, and a member of the ND Committee on Minority of Health Disparities.

Provider Associations:
ND Long Term Care Association, ND Community Facilities Association, Home Nursing Association. Long Term Care Social Workers of ND, Public Health Association

Providers:
County Social Service Case Management, County Social Services Board

Housing:
ND Community Action Association, County Housing Authority, NDHFA, ND Dept of Commerce-Division of Community Service, Medicaid Infrastructure Grant Housing Task Force Representative

Governmental Representatives:
Olmstead Commission Rep, Office of the Governor

Department of Human Services:
Executive office, Fiscal, Aging Services, Developmental Disabilities, ND Developmental Center, Regional Human Service Center Administration, Vocational Rehabilitation, Tribal Liaison, Medical Services-Long Term Care

Continuum, HCBS Services, Administration, Money Follows the Person Grant Program Administrator, Program Operations

Workgroups:
In addition the MFP Stakeholder Committee established five workgroups for the purpose of developing the operational protocol. These include the groups of Goals and Benchmarks, Nursing Facility Transitions, DC/ICF/MR Transitions, Housing, and Quality Assurance. The Stakeholder Committee reviews and gives final approval for all the work submitted by the workgroups. The workgroups include additional stakeholders not part of the larger MFP Stakeholder Committee. These workgroups include:

- **Goals and Benchmarks:** This workgroup is responsible for addressing the four primary objectives of the MFP Grant, grant benchmark design and review, case study development, and preparation of the operational protocol related to goal development.

  Membership includes representatives from the following groups/agencies:

  County Social Services Administration and Case Management, AARP Representative, ND Protection and Advocacy, Consumers, ND Long Term Care Association, ND Dept of Human Services, Aging Services Division, Center for Independent Living Representatives, Dept of Humans Services, Medical Services, Dept of Human Services, Developmental Disabilities, DHS, Money Follows the Person Grant Program Administrator, Older Americans Act Provider, The ARC of ND, Ann Carlson Center representative, a consumer, and a family member.

- **Nursing Facility Transitions**: This workgroup is responsible for the design of the new Transition Coordination demonstration service to be provided to consumers that wish to return to the community. This includes development of the processes, assessments, referral procedures, transition plans, forms, and policies necessary for successful transitioning to occur. Operational protocol related demonstration policy and procedures that address transitions from a nursing facility are the responsibly of this workgroup.

  Membership includes representatives of the following groups/agencies:

  HCBS Case Managers, Long Term Care Social Workers, Long Term Ombudsmen, Regional Aging Services Program Administration, ND Protection and Advocacy, IPAT, three consumers, Representatives of the Four Centers for Independent Living, Outreach Worker, Burleigh County Senior Adults Program, ND Public Health, and two consumers.

- **Developmental Center/Community ICF/MR Transitions:** This workgroup is responsible for the MFP operational protocol related implementation policies and procedures for all transitions from the Developmental Center and Community ICF/MR facilities.

  Membership includes representatives of the following groups/agencies:
  Developmental Disabilities State Office personal, ND Association of Community Facilities representative, DD Case Management, ND Developmental Center representatives, MFP Program Administrator, The ARC of ND, Protection and Advocacy of ND and the Developmental Center Transition Team and Committees, and one family member.

- **Housing:** This workgroup is responsible for the development of the strategies to assure that MFP participants have available, affordable, and accessible housing options. In addition the development of the operational protocol related to housing is the responsibility of this workgroup. Implementation of the housing strategies will also be addressed.

  Membership includes representatives of the following groups/agencies:
  ND Protection and Advocacy, ND Community Action Association, County Housing Authorities, ND Housing Finance Agency (NDHFA), ND Dept of Commerce-Division of Community Service, Long Care Association-Assisted Living Facility Representative, IPAT Coordinator, Center for Independent Living representative, MFP Program Administrator, CommunityWorks Housing Coordinator, Medicaid Infrastructure Grant Housing Task Force Representative

- **Quality Assurance:** This workgroup is responsible for the development of the operational protocol related to quality for transitions from nursing facilities and the Developmental Center/Community ICF/MR facilities. This includes addressing the required waiver quality assurance requirements and the three additional quality requirements of Incident management, 24 hour backup, and risk mitigation. This committee is responsible for the implementation of the demonstration service of 24 hour on call nursing services for all MFP participants.

- **Membership includes representatives of the following groups/agencies:**
  ND Protection and Advocacy, Department of Human Services, Medical Services Division-HCBS Waiver, Long Term Care Association-Nursing Facility Quality Assurance Representative, HCBS Case Management, County Social Services Administration, ND Association of Community Facilities, Department of Human Services, Developmental Disabilities, Developmental Center, ND Association

for Home Care, Vocational Rehabilitation, MFP Grant Program Administration, and the ND Department of Health (State Survey Organization)

Developmental Center – Transition to the Community Task Force

The Department convened a task force of stakeholders in 2005 to prepare a plan in response to the mandate from North Dakota House Bill 1012 – Section 16, to transfer appropriate Developmental Center residents to communities. The Superintendent of the Developmental Center chairs the task force and task force members include Department staff, community providers, advocates and family members. As a result of input from task force members, a statewide needs survey, and onsite stakeholder input sessions conducted in each of the eight state regional service areas, the task force determined community capacity needs to be built and resources need to be expanded in order to meet the current and projected needs of individuals in the community.

Recommended action steps developed by the task force to accomplish the transitioning of people to the community include: a community placement plan for each individual residing at the Developmental Center; a statewide crisis prevention and response system that is based on a “zero reject” model; increased need for crisis intervention services including crisis beds, out-of-home crisis residential services, in-home technical assistance, follow-along services after out-of-home crisis residential services placement, and enhanced training for community professional and direct care staff; increased consultation consisting of behavioral planning and oversight, sexual health, psychiatric and psychological issues. The Transition Task Force is acting in conjunction with the MFP demonstration grant to accomplish these goals. The MFP Grant Program Administrator is now a member of this task force and the recommendation for service system improvements to meet the support needs of persons with a developmental disability will be addressed to the extent possible within the operational protocol of the MFP Demonstration Grant.

Other Stakeholder Involvement

The ND Association Community Facilities conducted a Developmental Disabilities stakeholder meetings in January of 2008 using grant money provide by the ND Council on Developmental Disabilities for the purpose of identifying system improvements. The information from these meetings will be addressed by the MFP Stakeholder Committee and the Transitions to the Community Task Force.

Legislative Partnership Committee

This committee has also been established by stakeholders involved in the provision of services to persons with a developmental disability. The Committee includes state legislative representatives, Developmental Center personal, Parent representatives,

Consumer representatives, Guardianship provider representatives, Direct support professionals, ND Association of Community Facility representative, ARC of ND representatives, Developmental Disabilities Division Central Office representatives, ND Protection and Advocacy, ND Disabilities Advocacy Consortium representative, ND State Council on Developmental Disabilities, and the MFP Grant Program Administrator. The purpose of this committee is to assist state leadership to plan and respond to the support service needs of people who have a developmental disability. The group shares information directly with the Director of the Department of Human Services and the Governor's Office of ND. The findings of this committee will be addressed by the MFP Stakeholder Committee and the Developmental Center/ICF/MR Transitions workgroup.

Long Term Care Association

Six LTC Association regional meetings afforded the opportunity for significant input from nursing facility administrators, NF Directors of Nursing, and Social Service Staff related to the implementation of the grant. This information resulted in changes to the referral and notification process. The Long Term Care Social Workers of ND provided input during MFP training and representation on the MFP Stakeholder Committee.

Home and Community Based Services

The ND Adult Services Committee, the County Social Services Directors Association, and two Regional Councils on Aging met with the MFP Program Administrator and have provided direction and insight into the needs of persons that are elderly or that have a physical disability and are in need of HCBS in the community. Representatives of all of these groups agreed to participate in the MFP Stakeholder Committee.

MFP Benchmark-Stakeholder Group

To assist in rebalancing the state's long term care system, we will create a stakeholder committee led by the project manager for MFP in 2008. The committee will be comprised of individuals representing Governor's Olmstead Commission, Home Health, Housing Finance Agency, CIL's, Public Health, Senior Centers, Older American Act Providers, County Social Service Board Directors, Long Term Care Association, North Dakota Center for Persons with Disabilities, licensed DD community providers, and other interested parties.

The committee's purpose will be to educate consumers of rebalancing efforts, provide information to the ADRC on available resources, and identify activities and services lacking in communities. Additionally, the committee will develop a plan of action to enhance services in underserved areas of the state. Ongoing activities and accomplishments of the committee, educational resources made available to the public, as well as, rebalancing efforts enhanced, improved or implemented based on

recommendations by the committee will be reported annually or as requested by the grantor. The ND MFP Stakeholder Committee was created to meet this Benchmark. The Committee also will collaborate with the Aging and Disabilities Resource Center staff to meet the goals of this benchmark

Prior Stakeholder Contributions:

Information for development of the MFP demonstration was obtained from the Department's Systems Transformation work group consisting of consumers, Older Americans Act (OAA) service providers, county social service boards, AARP, Protection & Advocacy, Independent Living Centers, North Dakota Long Term Care Association, North Dakota Disabilities Consortium, local housing authorities, waiver service providers, and Department staff. Additional information was obtained through statewide Department stakeholder meetings and Aging Services/HCBS state input hearings. Other state agencies and divisions that have contributed in identifying service needs or providing information are Indian Affairs Commission, Health Department, Minot State University, Division of Mental Health & Substance Abuse, Disabilities Services Division, Aging Services Division, Vocational Rehabilitation, Civil Rights Office, and Legal Services Division. Input from advocates will be made through continued efforts of the Systems Transformation work group, as well as from stakeholder meetings held at least annually to obtain input on waivered services.

B.5 Benefits and Services

Target Population

The target population consists of North Dakotans who are currently residing in a nursing facility, or the ND Developmental Center, or in a community based ICF/MR for a period of 6 months or more, are receiving Medicaid, meet institutional level of care screening requirements, have been determined to be Medicaid eligible for the thirty day period immediately prior to transition, and are from one of the following populations:

1. Developmental Disabilities
2. Physically Disabled
3. Elderly

Institutions

Institutions covered in the ND Demonstration project include all skilled nursing facilities, community ICF/MR facilities, and the ND State Developmental Center.

Qualified Residences to Which Persons Will Be Transitioned

- A home owned or leased by the individual or the individual's family member;
- An apartment with an individual lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control; and
- A residence, in a community-based residential setting, in which no more than for (4) unrelated individuals reside to include Adult Family Foster Care or a Community Group Home

Individuals targeted will be those with a desire to transition from an institutional care setting to a home or community based services setting. Services will be provided by the Money Follows the Person Demonstration Grant Services. These demonstration services will mirror the current 1915(c) Waiver programs or Medicaid State Plan-Personal Care services currently being provided at this time.

Money Follows the Person Demonstration Services for Persons with a Physical Disability or an Elder

Waiver for HCB Services assists individuals to return or remain in their own homes or communities. Individuals must be Medicaid eligible, meet NF LOC

criteria, voluntarily choose to participate in the programs, and must be age 16 or over.

Home and Community Based Services Waiver Services

This waiver helps eligible individuals who would otherwise require nursing home services to return or remain in their homes or communities. It gives eligible people options, if their needs can be met in their homes.

Eligibility Requirements:

- To qualify for services under the HCBS Waiver program, an individual must be:
- A Medicaid recipient (meets Medicaid income and other eligibility requirements), and
- Screened at nursing facility level-of-care, and
- At least 16 years of age OR disabled by Social Security Disability criteria, and
- Living in his or her own home or apartment (not in dormitory or other group housing), and
- Able to have his or her service/care need(s) met within the scope of this waiver

Covered Services:

- Adult Day Care - Provides at least three hours per day of attended care in a group setting
- Adult Family Foster Care - Provides a safe, supervised family living environment, 24-hour per day in a state licensed setting
- Case Management - Assesses needs; helps with care planning, provider selection, referrals and service monitoring
- Chore Service - Includes snow removal and heavy cleaning
- Emergency Response System (Lifeline) - Provides telephone emergency response
- Environmental Modification - (Limited) Modifies the home to enhance the client's independence
- Homemaker Service - Provides house cleaning, laundry, and/or meal preparation services
- Non-Medical Transportation - Transports or escorts client for essential needs such as grocery shopping, social security office visit, etc.
- Residential Care - Services provided in a facility in which at least five (5) unrelated adults reside, and in which personal care, therapeutic, social, and recreational programming are provided in conjunction with shelter. This service includes 24-hour on-site response staff to meet scheduled and unpredictable needs and to provide supervision, safety, and security
- Respite Care - Provides temporary relief to full-time caregivers

- Specialized Equipment - Provides special equipment reducing the need for human help
- Home Delivered Meals-3 days per week – The purpose of home delivered meals is to provide a well-balanced meal to individuals who live alone and are unable to prepare an adequate meal for themselves, or who live with an individual who is unable to not available to prepare an adequate meal for the recipient. At a minimum, each meal must meet the most current meal pattern established by the United States Department of Agriculture's (USDA) Dietary Guidelines for Older Americans.
    - Services Eligibility Criteria – The individual receiving the home delivered mail will meet the following criteria:
        - Must be eligible for the Medicaid Waiver for Home and Community Based Services
        - Must not be eligible to receive home delivered meals under the Older Americans Act
        - Lives alone and is unable to prepare an adequate meal of lives with someone who is unable to or unavailable to prepare an adequate meal.
    - Service Limits – Recipients cannot receive more than 3 hot or frozen home delivered meals per week.
    - The individual will continue to receive home delivered meals under the waiver post demonstration period contingent on waiver eligibility.
- Extended Personal Care-Assistance with Medication
- Supported Employment Services - Provision of intensive, ongoing support to individuals to perform in a work setting with adaptations, supervision, and training relating to the person's disability. This would not include supervisory or training activities provided in a typical business setting. This service is conducted in a work setting, mainly in a work site in which persons without disabilities are employed
- Transitional Living Service - Services that train people to live with greater independence in their own homes. This includes training, supervision, or assistance to the individual with self-care, communication skills, socialization, sensory/motor development, reduction/elimination of maladaptive behavior, community living, and mobility.

    - North Dakota Technology Dependent Waiver assists individuals to remain in their own homes or communities. Individuals must be Medicaid eligible, meet NF LOC criteria, voluntarily choose to participate in the programs, dependent on a ventilator for a minimum of 20 hrs per day, medically stable and must be age 18 or over. Fee For Service. (Capacity of three slots)
    - Medically Fragile Children Waiver serves children ages 3-18 who would otherwise require nursing home services. Self-Directed. (Capacity of 15 slots)

- Medicaid State Plan-Personal Care (MSP-PC) provides personal care services to assists individuals to remain in their own homes or communities. Individuals must be Medicaid eligible, meet Level A criteria which included impairment in one ADL or impairment in 3 of the following 4 IADLs including meal preparation, laundry, taking medications and housework or Level B criteria which includes meeting Level A criteria and meeting NF LOC criteria. Fee For Service.

Additional Services Available for the Elderly and Disabled paid for by other state funding sources

Service Payments for the Elderly and Disabled (SPED).
http://www.nd.gov/dhs/services/adultsaging/homecare1.html

The SPED program provides services for people who are older or physically disabled and who have difficulty completing tasks that enable them to live independently at home.

Eligibility Requirements:

- Liquid assets less than $50,000
- Impaired in four Activities of Daily Living (ADL's) (bathing, dressing, toileting, eating, transferring, mobility inside) OR in five Instrumental Activities of daily Living (IADL's (meal preparation, housework, laundry, shopping, taking medication, mobility outside the home, transportation, money management, telephone)
- Impairments must have lasted or be expected to last three months or longer OR
- If an individual is younger than age 18, is screened for nursing facility level of care,
- Is not living in an institution, dormitory, or congregate housing
- The need for service is not due to mental illness or mental retardation, and the individual is capable of directing his or her own care or has legally responsible party, and has needs within the scope of covered services

Covered Services Include:

- Adult Family Foster Care - Provides a safe, supervised family living environment, 24-hours per day in a state licensed setting
- Case Management - Assesses needs, helps with care planning, provider selection, referrals, and service monitoring
- Chore Service - Includes snow removal and heavy cleaning
- Emergency Response System (Lifeline) - Provides telephone emergency response

- Environmental Modifications- (Limited) Modifies the home to enhance client independence (e.g. install safety rails)
- Family Home Care - Reimburses a family caregiver who meets the relationship requirements defined by state law and resides in a client's home 24-hours per day
- Homemaker - Provides house cleaning, laundry, and/or meal preparation services
- Personal Care - Helps with bathing, dressing, transferring, toileting, and supervision

Expanded Service Payments for the Elderly and Disabled (EX SPED).
http://www.nd.gov/dhs/services/adultsaging/homecare2.html

The Expanded-SPED program pays for in-home and community-based services for people who would otherwise receive care in a licensed basic care facility.

Eligibility Requirements:

- Medicaid eligible, and
- Receives or is eligible for Social Security Income (SSI), and
- Is not severely impaired in the Activities of Daily Living of toileting, transferring, eating, and
- Is impaired in three of four Instrumental Activities of daily Living: meal preparation, housework, laundry, or taking medications OR
- Has health, welfare, or safety needs, including supervision or structured environment, otherwise requiring care in a basic care facility, and
- Is not living in an institution or dormitory, and has needs within the scope of covered service

Covered Services Include:

- Adult Family Foster Care - Provides a safe, supervised family living environment, 24 -hours per day in a state-licensed setting
- Case Management - Assesses needs, helps with care planning, provider selection, referrals, and service monitoring
- Chore Service - Includes snow removal and heavy cleaning
- Emergency Response System (Lifeline) - Provides telephone emergency response
- Environmental Modifications (Limited) - Modifies the home to enhance client independence (e.g. install safety rails)
- Family Home Care - Reimburses a family caregiver who meets the relationship requirements defined by state law and resides in a client's home 24-hours per day

- Homemaker - Provides house cleaning, laundry, and/or meal preparation services
- Respite Care - Provides temporary relief to the full-time caregiver

Money Follows the Person Demonstration Services for Persons with a Developmental Disability

ND will be utilizing the current Developmental Disabilities service system to facilitate transitions from the Developmental Center and community ICF/MR facilities. During the MFP demonstration period the consumer's DD Case Manager will continue in their role as service broker however, they will additionally manage the MFP specific transition responsibilities. These responsibilities will include the provision of MFP program and rights related information to consumers/family/legal decision makers, securing MFP consent to participate documents, facilitating completion of transition plans that include risk mitigation and 24 hour backup planning, assuring transitions to qualified residences, facilitating applications for supplemental support services for one time transition costs, and ongoing case management follow-up after transition.

In addition the Developmental Center Social Worker will act as the primary contact person at the Center. The social worker will provide information to consumers or their family/legal decision maker about MFP demonstration services and supplemental services. The worker will also assure the provision or rights information, eligibility requirements are met, support planning is completed, and consent documentation is in place prior to a participant's transition to a community provider.

Qualified Home and Community-Based Services Available to Individuals with a Developmental Disability through the Demonstration Program

- Individualized Supported Living Arrangement (ISLA) – residential service providing support to individuals living in a home owned or leased by the individual.
- Qualified Group Home – community group home or community complex setting which provides training in community integration, social, leisure, and daily living skills to four or fewer unrelated individuals.
- Day Supports – a day program that may include assistance with acquiring, retaining, and improving skills necessary to successfully reside in a community setting.
- Supported Employment Extended Services – supports provided for individuals employed in the community.
- Family Support Services – family centered services that are provided for an eligible client in order for the client to remain in an appropriate home environment.
- Developmental Disabilities Case Management

- Homemaker – assistance with environmental maintenance tasks provided in the adult individual's home.
- Adult Family Foster Care – provision of food, shelter, security, safety, guidance, and comfort on a twenty-four hour day basis, in the home of the caregiver.
- Respite Care – temporary relief to the individual's primary caregiver from the stresses and demands associated with daily care or emergencies.
- Adult Day Health – non-residential activities encompassing health and social services.
- Self-Directed Supports – the opportunity to direct a fixed amount of public resources in a flexible manner that is meaningful and helpful in achieving personally defined goals so the individual may remain in the family residence or in their own home.
- Personal Care Services – allow the individual to live as independently as possible while delaying or preventing the need for institutionalization.
- Home Health Care – intermittent nursing care provided in home to prevent institutionalization.
- Durable Medical Equipment – equipment designed to meet the medical needs of the individual.
- Non-emergency medical transportation – provides transportation to medical appointments and medical services.

Current Programs Serving Persons with a Developmental Disability

Program Title and Summary:

- MR/DD Waiver which covers individuals of any age with mental retardation and/or developmental disabilities that would otherwise require the level of care provided in an intermediate care facility for mental retardation (ICF/MR), and meet ICF/MR Level of Care screening requirements. Fee For Service.
- Self-Directed Supports for Families (Ages 3-21)-The purpose of the program is to provide assistance for families with a member who requires long-term supports and services, or to individuals who require long-term supports and services, so that the individual may remain in the family residence or in their own home. Eligibility will be limited to those individuals who require long-term supports at a level typically provided in an institution and meet ICF/MR Level of Care screening requirements. Self-Directed.
- Self Directed Supports for Adults (Ages 21 and Over)-The purpose of the program is to provide assistance for families with a member who requires long-term supports and services, or to individuals who require long-term supports and services, so that the individual may remain in the family residence or in their own home. Eligibility will be limited to those individuals who require long-term supports at a level typically provided in an institution and meet ICF/MR Level of Care screening requirements. Self-Directed.

- Medicaid State Plan-Personal Care (MSP-PC) provides personal care services to assists individuals to remain in their own homes or communities. Individuals must be Medicaid eligible, meet Level A criteria which included impairment in one ADL or impairment in 3 of the following 4 IADLs including meal preparation, laundry, taking medications and housework or Level B criteria which includes meeting Level A criteria and meeting NF LOC criteria. Fee For Service.

NEW Money Follows the Person Services

Home and Community Based (Demonstration Services / Supplemental Services for Persons Transitioning from a Nursing Facility)

Nursing Facility Transition Coordination (Serving all population groups)

ND will provide the demonstration service of Nursing Facility Transition Coordination to individuals who reside in skilled nursing facilities. This service will provide needed supports to assist consumers with transition to a qualified residence of their choice prior to discharge and provide support services for one year following transition. This service will be offered statewide. Transition Coordination will be provided for up to 60 days prior to discharge as a demonstration service and all additional days as a supplemental service to meet the requirements of Interim Final Rule on Case Management.

The Transition Coordinator will educate potential MFP participants about the demonstration services available to assist with transition, secure consent for participation in services, provide MFP rights, appeal, and grant information, complete transition assessments, assist consumers to identify support service needs, communicate transition planning needs/issues during the discharge planning team process, assist consumers with the development of an Independent Living Plan, facilitate consumer preparation for transition, assure risk mitigation and 24 hour backup plans have been developed, and assure that all necessary arrangements have been made for successful transition.

The Transition Coordinator will provide consumer support for 365 days following transition to the community. The Independent Living Plan will be reviewed with the consumer within 45 days of transition to address any changing support needs of the consumer. The review of the Independent Living plan will include a review of the risk mitigation and 24 hour backup plans. Service delivery will be coordinated with the HCBS Case Manager involved with service delivery. Transition Coordinators will take the lead case management role during the 365 demonstration period. Visits will occur at a minimum of one time monthly for the first six months and every other month the second six months or more frequently as consumer need dictates.

Transition Coordination services will be provided by the four Centers for Independent Living serving ND including the Dakota Center for Independent Living of Bismarck; Independence Inc of Minot; Options Resource Center for Independent Living of East Grand Forks; and Freedom Resource Center of Fargo. A contract will be developed individually with each of the four Centers that will delineate the specific demonstration services to be provided for each MFP participant.

24 Hour on Call Nursing Service (Demonstration Service for all Money Follows the Person Participants)

To assure 24 hour backup to address health and welfare related needs of all MFP participants, ND will contract for a Nurse Call service. Consumers will be able to access the on-call Nursing Telephone Service 24 hours a day. The on-call Nurse will be able to assist the consumer by assessing crisis situations, contacting available service providers, and if needed will arrange for someone to go to the consumer's home to assess their situation and provide needed services. The consumer's Transition Coordinator or DD Case Manager will discuss this arrangement with the consumer during initial program application and again when the 24 hour back-up plan is developed. The consumer and their team will identify services in the community that will be able to address critical health and welfare needs on a 24 hour basis and provide this information to the on call nursing agency. The nursing agency will utilize this information during any call for services from the consumer. The consumer's primary mode of communication will be considered when developing the backup plan to assure access to the on call nursing service. The on call nursing service will not continue after the 365 days of MFP eligibility.

Supplemental Services (All Money Follows the Person Participants)

Supplemental services will be provided to all MFP participants. This service will assist with payment for one time transition costs. These items or activities may include but are not limited to the following:

- Health and safety technology (not otherwise covered by a demonstration service)
- Security and utility deposits
- Home modifications (not otherwise covered by a demonstration service)
- Adaptive equipment (not otherwise covered by a demonstration service)
- Home/Apartment furnishings-linens, dishes, small appliances, furniture
- Assistive technology devices (not otherwise covered by a demonstration service)
- One time modifications for a vehicle owned by the individual(not otherwise covered by a demonstration service
- Transition Coordination services (any services offered beyond 60 days)

Application Process for Supplemental Services

The Transition Coordinator, DD Case Manager, or the service provider for a person with a developmental disability will assist the consumer in making a request for payment of these items by submitting the Supplemental Services Request Form (Attachment B.5-A) to the MFP Program Administrator for approval. Each MFP participant will have up to $3,000 available to them to assist with transition costs. Requests for funds beyond the $3,000 allotment will be handled on a case by case basis by the MFP Grant Program Administrator. Alternative funding sources, consumer need, and grant money availability will all be considered when additional Supplemental Service funds request decision are made.

Money Follows the Person Eligibility

Participants will be eligible for demonstration services for a total of 365 days following transition from a qualified institution. Waiver services, State Plan Services, Service Payments for the Elderly and Disabled, and Expanded Service Payments for the Elderly and Disabled will be available on an ongoing basis following the demonstration contingent on the consumer meeting program eligibility requirements.

Qualified Home and Community Based Services to be Paid at the Enhanced FMAP Match Rate

HCBS Waiver

- Adult Day Care
- Adult Family Foster Care
- Case Management
- Chore Service
- Emergency Response System (Lifeline)
- Adult Residential
- Environmental Modification
- Homemaker Service -
- Non-Medical Transportation
- Respite Care
- Specialized Equipment
- Supported Employment Services
- Transitional Living
- Home Delivered Meals
- Extended Personal Care

Technology Dependent Waiver

- Attendant Care Service
- Case Management

Medically Fragile Children Waiver

- In-Home Supports
- Institutional Respite
- Transportation
- Equipment and Supplies
- Individual and Family Counseling
- Nutrition Supplements
- Environmental Modifications

MR/DD Waiver

- Case Management Services
- Homemaker Services
- Adult Day Health Services
- Habilitation Services
    a) Day supports
    b) Extended Services
    c) Waiver Group Homes
    d) Individualized Residential Supports (ISLA) (SLA)
- Family Support Services
    a) In-Home Supports
    b) FCO & FCO III
- Family Training-Infant Development
- Adult Family Foster Care
- Respite Care for Adult Family Foster Care

Self Directed Supports for Adults

- Self Directed In-Home Supports
- Employment Supports

Self Directed Supports for Families

- Self Directed In-Home Supports
- Disability Related Supports/Skilled Services
    a) Behavior
    b) Family or Individual Counseling
    c) Therapeutic Recreation
    d) Materials and Supplies

e) Transportation

Medicaid State Plan Services that will be paid at the enhanced FMAP rate

- Personal Care Services (All Money Follows the Person participants)

HCBC demonstration services that will be paid at the enhanced FMAP match rate

- Nursing Facility Transition Coordination (for 60 days) (Nursing Facility Transitions Only) (All Money Follows the Person participants
- 24 Nurse Call Services (All Money Follows the Person participants)
- All services normally provided under one of the state's 1915c waiver programs

Supplemental Demonstration services (for all Money Follows the Person Participants) include but are not limited to the following and will be paid at the regular FMAP rate

- Health and safety technology not otherwise covered under demonstration services
- Security and utility deposits
- Home modifications not otherwise covered under demonstration services
- Adaptive equipment not otherwise covered under demonstration services
- Home/Apartment furnishings-linens, dishes, small appliances, furniture
- Assistive technology devices not otherwise covered under demonstration services
- One time modifications for a vehicle owned by the individual
- Transition Coordination services (any services offered beyond 60 days)

Money Follows the Person Demonstration (Waiver) Services Available by Money Follows the Person Population Group

Waiver Service	MR/DD	Elderly	Physical Disability
HCBS Waiver Adult Day Care		x	x
Adult Family Foster Care		x	x
Chore Service		x	x
Emergency Response System (Lifeline)		x	x
Adult Residential		x	x
Environmental Modification		x	x
Homemaker Service		x	x
Non-Medical Transportation		x	x
Respite Care		x	x
Specialized Equipment		x	x
Supported Employment Services		x	x
Transitional Care		x	x
Technology Dependent Waiver Attendant Care Service		x	x
MR/DD Waiver Adult Day Health Services	x		
Habilitation Services Day supports Extended Services Waiver Group Homes Individualized Residential Supports (ISLA) (SLA)	x		
Family Support Services In-Home Supports FCO & FCO III	x		
Family Training-Infant Development	x		
Adult Family Foster Care	x		
Respite Care for Adult Family Foster Care	x		
Self Directed Supports for Adults Self Directed In-Home Supports Employment Supports	x		
Self Directed Supports for Families Self Directed In-Home Supports Disability Related Supports/Skilled Services Behavior Family or Individual Counseling Therapeutic Recreation Materials and Supplies Transportation	x		
Medically Fragile Children Waiver In-Home Supports Institutional Respite Transportation Equipment and Supplies Pediatric Specialty Services Individual and Family Counseling Nutrition Supplement Environmental Modifications	x		X
Case Management Services	x	x	X

Transition at Termination of Money Follows the Person Eligibility

Participants will be eligible for demonstration services for a total of 365 days following transition from a qualified institution. 1915(c) Waiver services, State Plan Services, and other state services including Service Payments for the Elderly and Disabled and Expanded Service Payments for the Elderly and Disabled will be available on an ongoing basis following the demonstration contingent on the consumer meeting program eligibility requirements.

North Dakota has adequate waiver slot availability to serve all Money Follows the Person participants at the end of their 365 day Money Follows the Person eligibility period. There are no waiting lists for waiver slots at this time and no waiting list is anticipated at any time during the Money Follows the Person demonstration period.

Prior to discharge from Money Follows the Person demonstration services a level of care screening will be completed to assure waiver eligibility. The screening will be completed by the waiver service broker within 60 days of Money Follows the Person eligibility termination. If a Money Follows the Person participant no longer meets nursing facility/ICF/MR level of care screening requirements other service programs will be offered to meet their needs based on eligibility. For persons that are elderly or with a physical disability these services will include the ND Service Payments to the Elderly and Disabled and Expanded Service Payments to the Elderly and Disabled, Older Americans Act Services, or Basic Care Services. For persons with a developmental disability these services will include case management, Supported Living Arrangement services, ND Service Payments to the Elderly and Disabled and Expanded Service Payments to the Elderly and Disabled, and other generic community services.

Money Follows the Person participants will be issued a Notice of Denial or Termination notice by the Money Follows the Person Grant Program Administrator prior to the end of their demonstration participation period or if they are found not to meet the established Money Follows the Person eligibility criteria (See Attachment B.5-B)

Appeals

Level of Care Appeals Process

The individual or legal representative may appeal the Level of Care eligibility decision within 30 days of the date of this notification. If the request for a hearing is received by the appeals supervisor within 10 days from the date of this notice, the funding for services may continue until an appeal decision is reached. However, all costs for services received must be paid back if the appeal is upheld. The individual may represent him/herself in an appeal hearing or may use a legal counsel, relative, friend, or other spokesperson. The reason for the appeal must be submitted in writing to:

Appeals Supervisor
North Dakota Department of Human Services
600 East Boulevard Avenue
Bismarck, North Dakota 58505-0250

The Appeals Supervisor processes administrative appeals. North Dakotans who have been denied public assistance benefits or whose benefits are reduced, terminated, discontinued, or suspended may appeal a decision in certain circumstances. The office also processes other kinds of appeals including foster care and daycare licensing, child abuse and neglect assessments, nursing home transfers and discharges, and rate setting.

An individual dissatisfied with a decision made regarding services may appeal that decision to the Department of Human Services under the fair hearing rules set forth in N.D.A.C. 75-01-03-03. An individual must be informed of the right to appeal any actions by the case manager or the department that result in denial, suspension, reduction, discontinuance, or termination care services.

Closures, Denials, Terminations, and Reductions in Services Policy (HCBS Waiver or State Medicaid State Plan Services)

1. Closures

If a client (either new or current client) does not utilize the services authorized in the care plan within a 30-day period of time, the case should close and an SFN 474, Closure/Transfer form, should be forwarded to HCBS Program Administration.

- If services were to be implemented within a few days after the 30th day, contact the HCBS Program Administrator for written approval.

County social service boards must notify HCBS Program Administration of HCBS closures using the SFN 474, Closure/Transfer form, this includes all HCBS programs. The Notification is to be submitted within 3 days of closing the case.

10-day Notice Not Required
Either because the client has taken action that results in the termination of services or it is a change in benefits that is not appealable, a 10-day notice is not required. The county is required to inform the client of the action taken to close their case. The notice may be a letter stating the effective date of the closure and the specific reason.

Note: If the case closure is due to death and the County has factual information confirming the client's death, a letter is not required to be forwarded to the client's estate. The source of the information should be documented in the case file.

Any of the reasons below do not require a 10-day notice:

a. County has factual information confirming the death of the client.
b. The county has received in writing the client's decision to terminate services
c. Client has been admitted to a basic care facility or nursing facility.
d. Client's whereabouts are unknown.
e. Special allowance granted for a specific period is terminated.
f. State or federal government initiates a mass change which uniformly and similarly affects all similarly situated applicants, recipients, and households.
g. Determined the client has moved from the area.

2. Denial/Termination Notice

The applicant/client must be informed in writing of the reason(s) for the denial/termination/Reduction. Complete SFN 1647 or send a letter with all applicable information to the client or applicant.

The Notice of Denial/Termination/Reduction is dated the date of mailing. contact the HCBS Program Administrator to obtain the legal reference required at "as set forth . . ." The legal reference must be based on federal law, state law and/or administrative code; reliance on policy and procedures manual reference is not sufficient.

When the client is no longer eligible for the HCBS funding, the County must terminate services under this funding source. Even if services continue under another funding source, the client must be informed in writing of the reasons s/he is no longer eligible under this Service Chapter.

The client must be notified in writing at least 10 days (it may be more) prior to the date of terminating services **UNLESS** it is for one of the reasons stated in this section. The date entered on the line, the effective date field, is 10 calendar days from the date of mailing the Notice or the next working day if it is a Saturday, Sunday, or legal holiday.

The county may send a cover letter with the Notice identifying other public and/or private service providers or agencies that may be able to meet the denied/terminated applicant/client's needs.

3. Former SPED or Ex-SPED Clients

A former SPED or Expanded SPED Program recipient can be reinstated without going through the SPED or Expanded SPED Program Pool if services are re-established within two calendar months from the month of closure. However, the HCBS Case Manager must determine that the former client is still eligible and what the current service needs are.

For the SPED program, forward the SPED Program Pool Data form and the MMIS form SFN 676 to HCBS Program Administration. The MMIS form should indicate the date the individual returned to services in the field “Medical Appr. Date”.

For the Ex-SPED program, forward the Ex-SPED Program Pool Data form and the MMIS form SFN 677 to the HCBS Program Administration. The MMIS form should indicate the date the individual returned to services in the field “Medical Appr. Date”.

The Transfer to Another County section of SFN 474 is to be used when an open case is transferred to another county. This section of the form is used when the client remains eligible for services but will not continue to reside in this county. Case information should be forwarded to the new county of physical residence.

For the Medicaid Waiver programs, in addition to submitting the SFN 474, the case manager must also submit the SFN 1288. In lieu of a closing date for Medicaid Waiver cases, the HCBS case manager must submit to Medical Services an end date for the level-of-care screening on the SFN 1288 when services will no longer be provided to the client. Whether the case is closed due to death or by issuance of a termination notice, submit an “end date” for the level-of-care to Medical Services and a copy to HCBS Program Administration.

Submitting an “end date” is required in order for the Department to have accurate data when submitting federal reports. A change will automatically be made in the screening information when a client enters a nursing facility or swing-bed unit.

See Attachments:

Attachment B.5-A – Supplemental Services Request Form
Attachment B.5-B – Notice of Denial or Termination of Demonstration Services

B.6 Consumer Supports

MFP participants will have access to assistance and supports, including back-up systems and supports, and supplemental supports in addition to usual HCBC service package.

Access

Participants will have access to assistance and supports in a variety of ways. The means of access will vary depending upon whether the individual seeks and receives assistance and support for a transition from a nursing facility or from the Developmental Center or a community ICF/MR facility. Individuals will primarily receive access and assistance through these four resources:

- Nursing Facility Transition Coordinators
- Home and Community Based Services Case Managers
- Developmental Disabilities Case Managers
- Developmental Center Social Worker

Nursing Facility Transitions

<u>Pre-Transition/Transition Services</u>

The ND Department of Human Services will contract with the four Centers for Independent Living serving ND to provide Nursing Facility Transition Coordination. Transition Coordination services include the provision of both pre-transition and transition services. The Transition Coordinator will provide the supports needed to assist nursing facility consumers with their transition to the community. The Transition Coordinator will also assist consumers with application for supplemental support services available for one time transition related costs. Transition Coordination services will also involve supporting consumer transitions for 365 days after their move from the nursing facility.

The four centers include the Dakota Center for Independent Living of Bismarck; Independence Inc of Minot; Options Resource Center for Independent Living of East Grand Forks; and Freedom Resource Center of Fargo. A contract will be developed individually with each of the four Centers that will delineate the specific demonstration services to be provided by the Center for each MFP participant.

Transition Coordinator Qualifications

- Completion of a bachelor's degree in sociology, social services, social work, or field related to programmatic needs from an accredited university, plus at least one year of progressively responsible experience in programs related to assignment; or,
- High school graduation, or its equivalent, plus at least four years of progressively responsible experience in programs or services related to assignment; or,
- High school graduation, or its equivalent, plus any equivalent combination and training and experience that provides the required knowledge, skills, and abilities

Knowledge, Skills, and, Abilities Requirements

1. Must have good organizational, planning, communication, and interpersonal skills, and work well as the member of a team. Individuals must be able to exercise diplomacy, tact and good judgment.
2. Ability to perform assessments with each consumer and to interpret information and certify eligibility for programs and services available in the community and those being offered under the Money Follows the Person Grant (MFP).
3. Ability to use SAMS and other computer programs, as relevant to successful completion of MFP activities.
4. Exercise the consumer's right to privacy and adherence to HIPAA guidelines.
5. Observes and documents details relative to an individual's needs and preferences for services and service providers.
6. Demonstrates knowledge of and working experience with long-term care programs, policies and financing in North Dakota.
7. Demonstrates knowledge of and working experience with services for seniors and persons with disabilities.
8. Demonstrates skills sufficient to market services and community supports to interested individuals.
9. Have access to reliable transportation and be able to travel in assigned regional service area on frequent basis.
10. To support the objectives of the MFP Grant.

Transition Coordinator to Participant Ratio

It is expected that the Transition Coordinator to Consumer Ratio will be ten to one during the demonstration period. The Coordinator will work in cooperation with nursing facility discharge planning teams to complete the tasks necessary for successful transitions.

Home and Community Based Services Case Management

Home and Community Based Services Case Management Services are being provided by county social services agencies.

HCBS Case Mangers perform case management for the aged or disabled. Case managers specifically provide information and referral services as needed; intake and need assessment; develop and implement individualized care plans for consumers; develop comprehensive service plans. During the MFP demonstration period the HCBS Case Manger will work with nursing facility discharge planning teams and the Transition Coordinator to assure needed services for consumers transitioning into the community and post transition supports are continued. They will provide referral information to potential MFP candidates and facilitate contact with the Center for Independent Living in their area that provides Transition Coordination services.

Home and Community Based Services Case Manager Qualifications

The HCBS Case Manager Position requires licensure as a Licensed Social Worker (LSW) by the North Dakota Board of Social Work Examiners (NDCC 43-41).

Home and Community Based Services Case Manager to Participant Ratio

It is expected that the HCBS Case Manager to participant ratio will be 60-70 to one for the demonstration period. HCBS Case Managers will work in cooperation with the NF Transition Coordinator and the nursing facility discharge planning teams to complete the tasks necessary for successful transitions.

Developmental Center and Community ICF/MR Transitions

Pre-transition Services/Transition services

Developmental Disabilities Case Managers are employees of the ND Department of Human Services and operate from Human Service Centers located throughout the State of ND. These locations include Williston, Minot, Devils Lake, Grand Forks, Fargo, Jamestown, Bismarck, and Dickinson. Each region has a Developmental Disabilities Unit serving their designated area of the state. Case Managers are supervised regionally by a DD Program Administrator with all services for persons with a developmental disability supported by Disability Services Division of the Program and Policy Office of the Department of Human Services.

Developmental Disabilities Case Managers in general are responsible for collecting data, assessing, organizing, coordinating, and evaluating professional services provided to persons with developmental disabilities and assisting them in gaining access to needed residential and day training, social, medical, educational, financial, protective and related services. Tasks included initial and on-going appraisal and assessment of consumer needs and their potential to achieve reasonable goals; collecting and maintaining pertinent data files on medical, psychological, social, and related program information. Organizes a team of concerned professionals and presents individual cases to the team and facilitates a service plan based on the needs of each consumer.

The DD Case Manager coordinates services to be provided to each consumer through continuous communication between consumer and service provider. This includes the tasks of negotiating reimbursement contracts with providers and evaluating client progress and services provided to insure satisfactory progress of service plan.

During the MFP demonstration period the DD Case Manager will continue in their role as service broker however will additionally manage the MFP specific transition responsibilities. These responsibilities will include the provision of MFP program and rights related information to consumers/family/legal decision makers, securing MFP consent to participate documents, facilitating completion of transition plans that include risk mitigation and 24 hour backup planning, assuring transitions to qualified residences, facilitating applications for supplemental support services for one time transition costs, and ongoing case management follow-up after transition.

DD Case Manager Qualifications

The DD Case Manager II position requires one year of experience as a Developmental Disabilities Case Manager I in the North Dakota Department of Human Services or meets the following North Dakota Department of Human Services definition of a Qualified Mental Retardation Professional (QMRP) is
a person who has at least one year of direct care experience working with persons with a mental illness or developmental disability; is a doctor of medicine or has a bachelor's or master's degree in one of the following fields: social work, psychology, counseling, nursing, occupational therapy, physical therapy, child development and family science, communication disorders (includes audiology or speech pathology), severely multiply handicapped, special education, vocational, rehabilitation, sociology, elementary education, recreation therapy, or human resources administration and management (human service track). (Certification or licensure in one of the above fields is not required for a QMRP designation)."

Case Manager to Participant Ratio

The average caseload of the mental retardation-developmental disabilities case management unit must be no more than sixty clients per case manager. DD Case

Managers will work in cooperation with Developmental Center discharge planning teams or with community ICF/MR discharge planning teams to complete the tasks necessary for successful transitions. http://www.legis.nd.gov/information/acdata/pdf/75-05-05.pdf

Developmental Center Social Worker

The ND Developmental Center is a State owned and operated institution under the umbrella of the Department of Human Services. The Center provides services to persons with a developmental disability whose needs are beyond the scope of support services provided by community services providers.

General duties of the Developmental Center Social Work are to work with the eight Regional Human Service Centers within North Dakota in the admission and discharge of individuals to and from the Developmental Center. Also coordinate the Developmental Center's outreach services to support people in maintaining their homes in their community. Serves as the contact person for guardians/families, teams and people served regarding information about community placement options, services provided at the Developmental Center, and surrogate decision making (guardianship) support and/or options.

The Center social worker will be the primary access or contact person for MFP demonstration services, support services, general information, eligibility, support planning, and consent documentation prior to a participants transition to a community provider.

Social Worker Qualifications

This position requires a Bachelors of Social Work and licensure as a Licensed Social Worker (LSW) by the North Dakota Board of Social Work Examiners (NDCC 43-41).

Social Worker to Participant Ratio

It is expected that the Social Worker to participant ratio will be 30 to one for the demonstration period. The Center Social Worker will work in cooperation with DD Case managers, Center discharge planning teams, and with community provider teams to complete the tasks necessary for successful transitions.

Additional Access

In addition to the four primary means of access, consumers may receive access through the MFP Grant Program Administrator, nursing facility social services professionals, ND

Protection and Advocacy Staff, Long Term Care Ombudsmen, and the Aging and Disabilities Resource Link.

Access may arise also through identification or referral from a variety of existing providers and resources including institutions and facilities such as hospitals, acute rehabilitation facilities, nursing facilities, assisted living facilities as well as through a variety of medical, DD, behavioral health, mental health and elderly care providers. These include Human Service Centers, medical providers, public and private agencies, private providers, home health care agencies, Qualified Service Providers, and Adult Day Programs.

24-Hour Emergency Back-Up Supports

The North Dakota Money Follows the Person Grant provides participant protection through the use of the statewide emergency backup system. This system will provide emergency response and backup in the event the consumer's own critical backup plans fail to ensure services and supports necessary to the consumer's health and safety. The primary emergencies likely to be faced by consumers are the failure of care providers to report for work, falls with injury, significant health changes, and extreme weather related situations. To maximize consumer choice and the principles of self-determination, consumers will select the providers of their choice for the emergency backup plan.

The levels of emergency backup provisions presented below, while providing necessary services, still reflect the philosophy of consumer choice. While adding additional layers of protection for the participants, it allows the consumer to select the plans that best fit his/her needs.

Hierarchy of Emergency Backup

The Money Follows the Person program will address the consumer's health and safety in the event of an emergency by the following hierarchy of backup protections. The levels vary by degree of emergency need. Generally a consumer will access these levels of backup in order, starting with Level 1. In case of extreme emergency, they may need to go directly to Level 3.

Level 1: Consumer Developed Emergency Backup Plans

Consumer's emergency backups for critical services will be incorporated into the Independent Living Plan/Individual Service Plan. The plan may include an informal network of family and friends, enrolled Medicaid provider agencies, Emergency Response Systems, alternative Qualified Services Providers, Center for Independent Living Staff, County Case Managers, Community Providers of

services to persons with a developmental disability, or other area service providers.

Level 1: Consumer Developed Emergency Backup Plans

The Money Follows the Person Grant program requires each consumer to include an emergency backup plan within his or her Independent Living Plan/Individual Service Plan. The emergency backup plan must identify specific arrangements necessary to provide critical services, transportation, or repair or replacement of equipment, and to maintain the health and safety of the consumer in the event of a breakdown in the routine plan of care. For the consumer, a critical service is one without which the participant would suffer an immediate risk to their health, safety, or well-being.

The plan provides a section devoted to the emergency backup planning. This page will include a description of each critical service. The plan must be detailed, realistic, and updated to keep pace with changes in the individual's Independent Living/Service plan. Transition Coordinators/ Developmental Disabilities Case Managers/Developmental Center Staff will work with consumers, their families, and area services provides to develop this plan. The plan may include an informal network of family, friends and neighbors, enrolled Medicaid provider agencies such as a home health, Emergency Response Systems, alternative Qualified Services Providers, Center for Independent Living Staff, County Case Managers, Community Providers of services to persons with a developmental disability, or other area service providers. The backup plan will be reviewed and/or updated after transition by the Transition Coordinator/DD Case Manager and/or consumer planning team after all critical incidents, during all team meetings, and no less than one time every six months. Changes to the plan will be communicated to the nursing call agency.

The consumer and planning team will prepare the contact information needed by the 24 hour nurse call service staff to provide necessary back up services.
Consumers may reach out to their network of family, friends, and neighbors to provide interim supports. Most consumers already rely on family and friends to provide some care giving and personal care services, and in the event of an emergency, these individuals may be able to provide additional care in the absence of the paid caregivers.

Level 2: 24 Hour Nurse Call Service

Consumers may access the Money Follows the Person Grant 24 hour on-call Nursing Telephone Service. The on-call Nurse will be able to assist the consumer by assessing crisis situation, contacting available service providers, and if needed will arrange for someone to go to the consumer's home to assess the situation and provide needed services. The consumer's Transition Coordinator or DD Case Manager will discuss this arrangement with the consumer during initial program application and again when the 24 hour back-up plan is developed

Level 2: 24 Hour Nurse Call Service

Consumers may access the Money Follows the Person Grant 24 hour on-call Nursing Telephone Service. The on-call Nurse will be able to assist the consumer by assessing crisis situation, contacting available service providers, and if needed will arrange for someone to go to the consumer's home to assess the situation and provide needed services. The consumer's Transition Coordinator or DD Case Manager will discuss this arrangement with the consumer during initial program application and again when the 24 hour back-up plan is developed. The consumer and their team will identify services in the community that will be able to address critical health and welfare needs on a 24 hour basis and provide this information to the on call nursing agency. The nursing agency will utilize this information during any call for services from the consumer.

Level 3: Extreme emergency

These levels are described in greater detail below:

Level 3: Extreme Emergency Backup

Beyond the above-required emergency backup plans, and in the event of an extreme emergency, the following services can be utilized.

Adult and Child Protective Services

In an emergency situation where there is possible abuse, neglect, and/or exploitation, or criminal activity the local police will be called. The case will be referred to Adult or Child Protective Services for an investigation until a safe resolution for the consumer is made. In cases where a consumer is in immediate jeopardy, Protective Services investigators and caseworkers will work to arrange for providers that can provide safe

placement for consumers. These services may include providers such as nursing facilities, foster care homes, alternative DD Provider Agencies.

The Transition Coordinator or the DD case manager will provide information and telephone numbers to consumers and their families for Adult Protective Services, ND Protection and Advocacy, and Child Protective Services upon enrollment. In addition, Protective Services will investigate reports by any citizen that suspects abuse or neglect.

Division of Emergency Management

In the event of natural or man-made disasters, the North Dakota Division of Emergency Management coordinates disaster relief through North Dakota County Emergency Management Agencies. These regional offices in turn coordinate with community-wide organizations in the event of a disaster. Each state agency has in place contingency plans for their particular constituency in the event of fire, tornado, flooding, or terrorism. These plans include assisting individuals with disabilities with evacuation and/or continuity of critical services.

Emergency 911 Services

All Money Follows the Person consumers are advised to call the emergency telephone number 911 in the event of a crisis where health or safety is in immediate jeopardy.

24 Hour Nurse Call Service Oversight

ND will contract with a 24 hour Nurse Call service to provide the backup services for MFP participants during their demonstration period. An informal request for proposal process will be utilized to select this service provider. A contract will be developed that outlines the requirement to track number and types of calls received for services, call response times, and consumer outcomes. Daily, weekly, quarterly, and yearly reporting of utilization will also be expected of the call service. Consumers will be provided with the back-up nursing service agency name, phone numbers, and contact names in MFP participant/ consumer information materials.

The MFP Grant Program Administrator will monitor call response frequency, quality of response, and viability of consumer backup plans as part of the MFP quality assurance process. This will include review of the call system quality with the MFP Quality workgroup, and the Stakeholder Committee. Concerns identified related to the 24 hour backup plans will be communicated to the Transition Coordinator or DD Case Manager for review and follow-up.

Access to Appeals and Protective Services

If a participant in the MFP demonstration services has a complaint or concern about services received every effort will be made to deal with the issue on an informal basis or with a referral to an advocacy group such as the ND Protection and Advocacy Office or Ombudsman's Office. If however the complaint cannot be resolved the MFP participate will be referred to the ND Department of Human Services Appeals Supervisor to address the complaint through the administrative appeals process.

The Appeals Supervisor processes administrative appeals. North Dakotans who have been denied public assistance benefits or whose benefits are reduced, terminated, discontinued, or suspended may appeal a decision in certain circumstances. The office also processes other kinds of appeals including foster care and daycare licensing, child abuse and neglect assessments, nursing home transfers and discharges, and rate setting. Contact Information:

> Appeals Supervisor, Legal Advisory Unit, N.D. Department of Human Services, 600 E Boulevard Avenue, Dept. 325, Bismarck, ND 58505-0250; Phone: (701) 328-2311, Toll Free: (800) 472-2622 TTY: (701) 328-3480, dhslau@nd.gov

An individual dissatisfied with a decision made regarding services may appeal that decision to the Department of Human Services under the fair hearing rules set forth in N.D.A.C. 75-01-03-03. An individual must be informed of the right to appeal any actions by the case manager or the department that result in denial, suspension, reduction, discontinuance, or termination of care services.

75-01-03-03. Fair hearing - Who may receive.

1. An opportunity for a fair hearing is available to any applicant for or recipient of food stamps; aid to families with dependent children; job opportunities and basic skills training program; employment, education, or training-related child care; transitional child care; Medicaid; children's health insurance program; or low income home energy assistance program bene□ts who requests a hearing in the manner set forth in this chapter and who is dissatis□ed:

    a. Because an application was denied or not acted upon with reasonable promptness; or
    b. Because county agency or department action has resulted in the suspension, reduction, discontinuance, or termination of bene□ts.

2. An opportunity for a fair hearing is available to any resident who believes a facility has erroneously determined that the resident must be transferred or discharged.

3. An opportunity for a fair hearing is available to any individual who requests it because the individual believes the department has made an erroneous determination with regard to the preadmission and annual review requirements of 42 U.S.C. 1396r(e)(7).

4. The department may, on its own motion, review individual cases and make determinations binding upon a county agency. An applicant or recipient aggrieved by such determination shall upon request be afforded the opportunity for a fair hearing. All references in this chapter to appeals from decisions of county agencies must be understood to include appeals taken from determinations made by the department.

5. A fair hearing request may be denied or dismissed when the sole issue is one of state or federal law requiring automatic benefit adjustments for classes of recipients unless the reason for an individual appeal is incorrect benefit computation.

6. The claimant may first seek corrective action from the department or claimant's county agency before □ling a request for a fair hearing.

7. If a claimant dies after a request for a fair hearing has been □led by the claimant, and before the decision of the department has been rendered in the case, the proceedings may be continued on behalf of the claimant's estate, or any successor, as that term is de□ned in North Dakota Century Code section 30.1-01-06, of the claimant if a representative of the estate has been appointed.

8. If a dissatis□ed claimant dies before the claimant can □le a request for a fair hearing, the duly appointed representative of the claimant's estate, or any successor, as that term is de□ned in North Dakota Century Code section 30.1-01-06, of the claimant if no representative of the estate has been appointed, may □le such request when the claimant was dissatis□ed with the denial of the claimant's application for assistance, or was dissatis□ed with the bene□ts the claimant was receiving prior to the claimant's death.

9. A fair hearing under this section is available only if:

    a. Federal law or regulation requires that a fair hearing be provided; and
    b. The dissatis□ed claimant timely perfects an appeal.

The ND MFP Rights document (Attachment B.2-B) has contact information for all of the agencies that will assist participants with appeals or protective service interventions. The contacts are listed below to provide an overview of all of the agencies and services available to meet the needs of MFP participants. The following sections outline the services available and the populations that they serve.

Client Assistance Program

The North Dakota Client Assistance Program (CAP) works with people who have applied for or are receiving services under the Rehabilitation Act. Its mission is to resolve issues or concerns individuals may have as they work with the agencies or programs that provide these services. In North Dakota the agencies and programs include:

- Centers for Independent Living
- Vocational Rehabilitation
- Tribal Vocational Rehabilitation

The Centers for Independent Living offer the Client Assistance Program to address complaints related to the services that are provided by their agencies other than MFP Transition Coordination services

The CAP also provides information about the employment regulations pertaining to the Americans with Disabilities Act (ADA). http://www.nd.gov/cap/

The Protection & Advocacy Project

The Protection & Advocacy Project (P&A) is a state agency whose purpose is to advocate for, and protect the legal rights of people with disabilities.
http://ndpanda.org/

P&A has seven different advocacy programs that serve individuals with disabilities:

1. Developmental Disabilities Advocacy Program;
2. Mental Health Advocacy Program;
3. Protection and Advocacy Project for Individual Rights;
4. Protection and Advocacy for Beneficiaries of Social Security;
5. Assistive Technology Advocacy Program.
6. Help America to Vote Program(HAVA)
7. Protection and Advocacy for Individuals with Traumatic Brain Injury

Protection & Advocacy Project Office address:

Wells Fargo Bank Building, 400 East Broadway, Suite 409
Bismarck, ND 58501-4071; Phone: 701-239-7222, Fax: 701-239-7224
panda@nd.us

Vulnerable Adult Protective Services

A vulnerable adult is any person older than age 18, or emancipated by marriage that has a substantial mental or functional impairment.

Reporting

N.D. Century Code (ND State Law) states that any person who reasonably believes that a vulnerable adult has been subjected to abuse or neglect or observes conditions or circumstances that reasonably would result in abuse or neglect may report the information to the department or to an appropriate law enforcement agency. In addition a consumer has the ability to self-report any abuse that they have experienced from a care giver at any time. The Transition Coordinator will provide education to all persons transitioned about the need to report abuse or neglect by a caregiver. The Transition Coordinator will continue to monitor service delivery including how the consumer is being treated by their caregivers.

Under the law, the N.D. Department of Human Service has the right to assess and to provide or arrange the provision of adult protective services, if the vulnerable adult consents and accepts the services. May pursue administrative, legal, or other remedies authorized by law, which are necessary and appropriate to protect a vulnerable adult who cannot give consent, and to prevent further abuse or neglect.

Seeking Services or Reporting Suspected Abuse or Neglect

To contact a vulnerable adult protective service worker in your area please contact your Regional Human Service Center.

Human Service Center Contact Information:

Bismarck – 701-328-8888 or 888-328-2662
Devils Lake – 701-665-2200 or 888-607-8610
Dickinson – 701-227-7500 or 888-227-7525
Fargo – 701-298-4500 or 888-342-4900
Grand Forks – 701-795-3000 or 888-256-6742
Jamestown – 701-253-6300 or 800-260-1310
Minot – 701-857-8500 or 888-470-6968
Williston – 701-774-4600 or 800-231-7724

Another Resource:

North Dakota Senior Info Line (Aging and Disabilities Resource Link)
1-800-451-8693; www.ndseniorinfoline.com; Produced January 2007

N.D. Department of Human Services
Aging Services Division
600 E Boulevard, Department 325
Bismarck N.D. 58505-0250
Phone: 701-328-4601 TTY: 701-328-3480
www.nd.gov/humanservices

Reporting Suspected Child Abuse or Neglect

A person mandated to report, or any person wanting to report suspected child abuse or neglect, should contact the County Social Service Office in the county where the child is. Each of the 53 County Social Service Offices serve as the N.D. Department of Human Services' designee for child protection services.

- Reports of suspected child abuse or neglect may be made verbally or in writing;
- If requested by the county social service office, a verbal report must be followed by a written report;

The state's reporting form, SFN 960, is available at county social service office or online.

Institutional Child Protection Services

Institutional child abuse and neglect is defined by North Dakota Century Code 50-25.1-02 as, "situations of known or suspected child abuse or neglect where the person responsible for the child's welfare is an employee of a residential child care facility, a treatment or care center for mentally retarded, a public or private residential educational facility, a maternity home, or any residential facility owned or managed by the state or a political subdivision of the state."

When a child is suspected of being abused under circumstances that fit within this definition, the suspicion of possible child abuse or neglect can be reported to the regional supervisor of child protection services at the Regional Human Service Center in the region where the facility is located. Certain professionals are required by law to make reports whenever child abuse or neglect is suspected. (State Form Number 960 may be used to make a report of suspected institutional child abuse or neglect).

Long Term Care Ombudsman Program

- Receives, investigates, and works to resolve concerns affecting residents
- Answers questions and provides information and referral services
- Promotes resident, family, and community involvement in long-term care facilities

- Promotes community education about long-term care issues
- Coordinates efforts with other agencies and organizations
- Identifies issues and problem areas, and recommends needed changes

The Ombudsman Program Serves

- Residents of nursing facilities, assisted living facilities, basic care homes, and hospital swing bed, transitional and sub-acute settings
- Families and friends of residents
- The general public
- Employees and administrators of long-term care facilities
- Various regulatory, certification, and other agencies

Services are provided by long term care ombudsmen at the Regional Human Service Centers and by volunteer community ombudsmen who are trained by the department and who volunteer their time to serve residents of long-term care facilities. See Fact Sheet (52kb pdf).

Volunteer Community Ombudsmen

- Are recruited and trained by the Department of Human Services and are assigned to serve at long-term care facilities in their local communities
- Listen to residents' concerns, help protect resident's rights, and assure that residents receive fair treatment
- Provide long-term care residents with information about their rights and community resources

B.7 Self-Direction

Nursing Facility Transitions

Individuals included in the demonstration will be provided services primarily through an approved Section 1915(c) Home and Community Based Services waiver system and providers. During the time a consumer participates in the MFP grant process these will be MFP demonstration services paid for with MFP grant dollars and not waiver services. An assurance within this system is that consumers are provided with a choice of MFP Demonstration services or institutional services. By electing to receive HCBS waiver services, the individual is provided a choice of available providers. In most situations, individuals will receive MFP Demonstration HCBS services while residing in a leased apartment setting. The state assures that participants will have a choice in selecting their community residence, since the consumer/family member or legal decision maker is the lessee, they cannot reside in that setting unless willingly entering into a legal lease arrangement.

The state assures that all Medicaid eligible individuals and/or their authorized representatives that reside in a nursing facility and have expressed a preference to return to the community will be informed of the demonstration project and will be given the opportunity to communicate their choice to participate in the MFP Demonstration.

North Dakota has an established system whereby an individual is assisted by a case manager in identifying service needs and then allowing the individual to choose or recruit a Qualified Service Provider (QSP), to provide for those identified needs. QSPs are individuals or agencies enrolled by the state as independent contractors to provide a myriad of services that individuals need. Individuals have the opportunity to self-direct care by selecting QSPs already enrolled or encouraging caregivers to enroll. County Social Service agencies are provided with a list of QSPs by the Department of Human Services on a monthly basis. The county case managers provide consumers with a list of available QSPs in their area. The consumer can select the QSPs that they wish to work with and/or recruit additional persons to serve as a QSP.

North Dakota has an established system that allows both individual persons and agencies to enroll with the Department of Human Services as Qualified Service Providers (QSPs) to provide home and community based services. The process is competency based with the competency verified by a health care professional, or the individual or agency can provide evidence or documentation of the ability to provide a specific service. The ability to enroll providers, based on competency to provide a service, allows an individual to recruit a person or agency of their choice and encourage that person or agency to seek enrollment as a QSP.
During the 2007 legislative session, increases to the rates paid to QSPs were approved and the advocacy organizations are supportive of continued improvement in the rates paid to QSPs.

Person Centered Planning

The development of Independent Living Plans for all transitions from a nursing facility will be based on the guiding principles of consumer and family involvement and consumer choice and control. Independent Living Planning will be a personalized, interactive and ongoing process to plan, develop, review, and evaluate the services in accordance with the preferences and desired outcomes of the consumer. A written Independent Living Plan will be developed for each consumer utilizing a person-centered planning process that reflects the needs and preferences of the consumer.

This is a process that is designed to empower the consumer to the extent possible within the current service delivery system. Consumers will be assisted in learning how to choose QSPs and schedule them in the ways that best meet the consumer's schedule and needs. While budget choice currently is not offered, the consumer is made aware of the services approved and the time allotted by the case manager to meet those needs so that they can develop their own plan for care delivery.

North Dakota Developmental Center and Community Based Intermediate Care Facilities for the Mentally Retarded Transitions

For Medicaid eligible individuals residing in ICF/MRs, the service and community preferences of the person, and/or their authorized representative, help guide the priority for discharge planning from the Developmental Center (DC) and are recorded in the Residential Decision Profile as: 1) clearly wants to leave DC to live elsewhere now/soon; 2) generally appears to want to leave DC, but the decision may not be firm because it varies, is not completely clear, or there are some reservations; 3) unclear which way the person prefers; 4) generally appears to want to stay at DC, but the decision may not be firm because it varies, is not completely clear, or there are some reservations; or 5) clearly wants to stay at DC.

The state assures an individual will be informed of alternatives services available through the demonstration project and that each individual is offered choices of services and community residences. These choices must be agreed to by the individual in the individual's transition plan which identifies the demonstration services to be furnished, the individual's choice of providers, informal supports, and type of residence.

All individuals receiving services in community ICF/MRs are assigned a case manager from the regional Human Service Center to authorize and monitor services. This function includes ensuring individuals have choice between ICF/MR and MFP demonstration services and of the least restrictive service setting that will meet their needs.

ND offers two Independence Plus self-directed supports waivers for children and adults with developmental disabilities effective April 1, 2006. Self-directed supports give

individuals and their families' greater choice and control in making decisions and obtaining support, and include the option of directing a fixed amount of public dollars through an individual budget. The self-directed supports waivers are based upon the belief that in order for eligible individuals with developmental disabilities and their families to fully participate in their communities, they must define the life they seek and be supported as they direct the generic and formal supports. These self-directed supports will be utilized as MFP demonstration services for persons that participate in the MFP process.

Person Centered Planning

The development of individual plans of care/Service/Support Plans will be based on the guiding principles of individual and family involvement and consumer choice and control Service planning/Support Planning will be a personalized, interactive and ongoing process to plan, develop, review and evaluate the services in accordance with the preferences and desired outcomes of the individual/family.

A written plan of care will be developed for each individual utilizing a family or person-centered planning process that reflects the needs and preferences of the individual and their family.

Family or person-centered planning is a process, directed by the family or the individual with long-term care needs, intended to identify the strengths, capacities, preferences, needs and desired outcomes of the individual. The family or individual directs the family or person-centered planning process. The process includes participants freely chosen by the family or individual who are able to serve as important contributors. The family or person-centered planning process enables and assists the individual to identify and access a personalized mix of paid and non-paid services and supports that will assist him/her to achieve personally-defined outcomes in the most inclusive community setting. The individual identifies planning goals to achieve these personal outcomes in collaboration with those that the individual has identified, including medical and professional staff.

All services will be furnished pursuant to a written plan of care. This plan of care will describe the services and supports (regardless of funding source) to be furnished, their projected frequency, and the type of provider who will furnish each. The plan of care will address how potential emergency needs of the individual will be met. The plan of care is subject to the approval of the Medicaid Agency.

<u>Self Directed Supports</u>

ND offers two Independence Plus self-directed supports waivers for children and adults with developmental disabilities were effective April 1, 2006. Self-directed supports give individuals and their families' greater choice and control in making

decisions and obtaining support, and include the option of directing a fixed amount of public dollars through an individual budget. The self-directed supports waivers are based upon the belief that in order for eligible individuals with developmental disabilities and their families to fully participate in their communities, they must define the life they seek and be supported as they direct the generic and formal supports. These self-directed support programs offer eligible individuals and their families the opportunity to direct a fixed amount of public resources in a flexible manner that is meaningful and helpful in achieving their personally defined goals.

North Dakota Self Directed Supports for Families

The purpose of the program is to provide assistance for families with a member who requires long-term supports and services, or to individuals who require long-term supports and services, so that the individual may remain in the family residence or in their own home. Eligibility is limited to those individuals who require long-term supports at a level typically provided in an institution.

The State has the flexibility to define a range of community-based services that will support families and individuals. Families and individuals will work with the State to identify, through a family or person-centered planning process, those services and supports needed to avoid placement in an institutional setting or placement in group living arrangements of greater than four persons. The State will maintain the ability to control costs and, in conjunction with individuals or families, establish mutual expectations regarding available resources. These resources will be identified through an established methodology, open for public inspection, for determining an individual budget that would be based upon actual service utilization data. Through the provision of services and supports identified through the plan of care and the operation of a quality assurance and improvement program, the State will ensure the health and welfare of the individuals in the program. In addition, the program will provide assurances of fiscal integrity and include participant protections that will be effective and family-friendly. http://www.nd.gov/dhs/services/disabilities/docs/nd-sds-for-families-i-w-application-2006-01.pdf

North Dakota Self Directed Supports for Adults

The purpose of the program is to provide assistance for families with a member who requires long-term supports and services, or to individuals who require long-term supports and services, so that the individual may remain in the family residence or in their own home. Eligibility will be limited to those individuals who require long-term supports at a level typically provided in an institution, as specified in this application.

The State has the flexibility to define a range of community-based services that will support families and individuals. Families and individuals will work with the State to identify, through a family or person-centered planning process, those services and supports needed to avoid placement in an institutional setting or placement in group living arrangements of greater than four persons. The State will maintain the ability to control costs and, in conjunction with individuals or families, establish mutual expectations regarding available resources. These resources will be identified through an established methodology, open for public inspection, for determining an individual budget that would be based upon actual service utilization data.

Through the provision of services and supports identified through the plan of care and the operation of a quality assurance and improvement program, the State will ensure the health and welfare of the individuals in the program. In addition, the program will provide assurances of fiscal integrity and include participant protections that will be effective and family-friendly.
http://www.nd.gov/dhs/services/disabilities/docs/nd-sds-for-adults-i-w-application-2006-01.pdf

Fiscal Agent

The Fiscal agent, ACUMEN, assists the family or individual to manage and distribute funds contained in the individual budget including, but not limited to, the facilitation of the employment of service workers by the family or individual, including Federal, state, and local tax withholding/payments, unemployment compensation fees, wage settlements, fiscal accounting and expenditure reports.

Self Directed In-Home Support

The hourly rate used to determine the individual budget amount for Self Directed In-Home Supports cannot exceed a maximum hourly rate established by the Department of Human Services. Although a standard hourly rate will be used to determine the budget amount for Self Directed In-Home Supports, the consumer will have the flexibility to negotiate the rate at which they will compensate their selected providers. The individual budget dollar amounts for Disability Related Supports will be calculated based on excess expense estimates agreed upon by the family and Support Broker, but the family will also have the flexibility to negotiate the rate at which they will compensate their selected providers.

If the individuals documented needs exceed service utilization limits, the DD Case Manager/Support Broker may request an exception from the Disabilities Services Division (DD Unit) of the ND Department of Human Services.

To ensure consistency, Individual budgets are entered in a Lotus Notes Database. Through a workflow and approval process, the database tracks the individual budgets from the DD Case Manager/Support Broker, through the Regional DD Program Administrator, to the state level central office administrator. Edits are built into the database to prevent errors. The database also calculates total funds authorized and tracks areas in which funds are allocated. At the end of a budget period the database is updated to reflect actual funds expended.

Self Directed Support Authorizations/Individual Budgets will contain information regarding the consumer/legal guardian's rights if supports are suspended, terminated or reduced.

B.8 Quality

North Dakota Home and Community Based Services Quality Assurance Overview

The state has a quality assurance system that identifies key components, practices, and utilizes the quality framework methodology. Within this working document the following assurances will be addressed, Level of Care Determination, Service Plans, Qualified Providers, Health and Welfare, Administrative Authority, and Financial Accountability.

The State's quality management system is the framework for North Dakota's Home and Community Based Waivers. North Dakota HCBS Waiver for HCBC Services ND .0273, North Dakota Technology Dependent Waiver ND 02.00.00, and Medically Fragile Children Waiver ND 0568have an approved Appendix H: Quality Management Strategy.

ND also has three waivers that serve the Developmentally Disabled consumer population which include MR/DD Waiver 0037.90.R3.02, Self-Directed supports for Families 0421, and Self Directed Supports for Adults, 0422. The MR/DD Waiver is currently in the renewal process and quality evidence narrative has been submitted for review and approval.

The Money Follows the Person core team includes DD Division state office staff, the Medical Services HCBS Program Administrators, DHS fiscal staff, and the MFP Grant Program Administrator. The MFP Program Administrator has overall responsibility for Quality assurance planning for individuals transitioning to the community from Nursing Facilities and ICF/MRs and utilizing services through the MFP grant.

The HCBS Quality Management team for Medicaid Waiver HCBS, Technology Dependent Waiver, Service Payments for the Elderly and Disabled (SPED), Expanded SPED, and Medicaid State Plan Personal Care include the Assistant Medical Services Director responsible for the Long Term Care Continuum, who has overall responsibility for the team, four Human Service Program Administrators (HSPA), and two support staff. One program HSPA IV is the team leader and administrates policy and procedures for all service programs. This individual supervises the Human Service Program Administrator III positions. These individuals are responsible for the Qualified Service Provider (QSP) enrollment process, review process, and complaint resolution. The other HSPA IV is responsible for waiver administration and eligibility, state funded program eligibility, QSP rate setting and supervision of support staff.

The Quality Management Framework Plan is outlined in the approved section H of the Medicaid Waiver for Home and Community Based Services and the approved section H of the Technology Dependent Waiver. The same plan extends to consumers receiving services through state funds and through the Medicaid State Plan Option. The programs included are, Service Payments for the Elderly and Disabled (SPED), Expanded Service Payments for the Elderly and Disabled (EX SPED), and Medicaid State Plan Personal Care (MSP-PC).

The above programs are similar in some respects but vary in specific guidelines including functional eligibility and financial eligibility guidelines. In addition client's maybe receiving services from more than one of these programs during a concurrent period of time. These programs serve approximately 2,550 individuals. HCBS Case Managers develop care plans for clients receiving services through the HCBS Waiver, Tech Dependent Waiver, SPED, EX- SPED, and Medicaid state plan personal care services. DD Case Managers develop care plans for Medicaid State plan personal care services for approximately 50 consumers and HCBS Case Managers develop care plans for the remaining 2500 consumers.

DD Division Quality Team for the three DD Waivers includes the Director of Medical Services, the Director of the DD Division, three HSPA IVs, one HSPA III and two support staff. One HSPA IV is responsible for the family support programs, children's residential services, early intervention services and Part C coordination, one HSPA IV is responsible for Adult Day and Residential Services, Licensing of DD Providers, ISLA contracts, and the other HSPA IV is responsible for overall quality assurance, PASRR, Institutional Liaison, and DD Case Management. The HSPA III coordinates the corporate guardianship and the DD Training Module contracts, reviews provider-employee background checks, and completes the waiver financial reports.

North Dakota's overall quality management system for persons with mental retardation and developmental disabilities encompasses: Medicaid certification and inspection of care for intermediate care facilities for the mentally retarded; licensing of program and services by the Department; provider accreditation by The Council on Quality and Leadership; policies addressing provider responsibilities to report and investigate alleged incidents of abuse, neglect or exploitation involving service participants; the North Dakota Community Staff Training Program; monitoring by DD case management; coordination with North Dakota's Protection and Advocacy Project; and coordination and involvement of Catholic Charities North Dakota, the corporate guardian for over 370 persons with developmental disabilities.

The CMS Quality Framework describes quality outcomes for HCBS under seven focus areas: individuals have access to home and community-based services in their communities; services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning his/her life in the community; there are sufficient HCBS providers and they possess and demonstrate the capability to effectively serve participants; participants are safe and secure in their homes and communities, taking into account their informed and expressed choices; participants receive support to exercise their rights and in accepting personal responsibilities; participants are satisfied with their services and achieve desired outcomes; and the system supports participants efficiently and effectively, and constantly strives to improve quality. Taken together, these outcomes define quality for an HCBS program. Embedded within each of these outcomes are processes that, when implemented carefully, will yield the desired effect or quality.

The new services available under the MFP Grant

Nursing Facility Transition Coordination demonstration/supplemental service, Supplemental Services for the payment for one time transition costs, and a 24 hour nursing call service are the three new services to be offered through the Grant. This document will describe the quality assurance process for these services.

Quality Assurance Roles of Stakeholder Committee

The Money Follows the Person Grant has established a stakeholder committee and five subcommittees that include consumers and/or their family members, advocacy groups, provider association representatives, State agency staff, and housing agency representatives. Stakeholder participation is considered vital to the success of the implementation of the Money Follows the Person Rebalancing demonstration Grant. The general responsibilities of the committee include:

- Provide ongoing oversight and/or advice on State policy changes to achieve rebalancing.
- Monitor grants implementation progress.
- Monitor achievement of grant benchmarks.
- Suggest ways to improve program design or implementation.
- Participate in the design of the operational protocol (OP).
- The OP will serve as the grant implementation policy.
- Monitor OP implementation throughout the grant period.
- Educate consumers of rebalancing efforts.
- Provide information to the ADRC on available resources.
- Identify activities and services lacking in communities.
- Develop a plan of action to enhance services in underserved areas of the state.

The Stakeholder committee will meet formally four times per year to monitor grant implementation. The workgroups meet as needed or as directed by the stakeholder committee to address implementation strategy, suggested policy changes, or other concerns as identified. The MFP Quality Workgroup will meet two to four times per year to address quality related issues identified during the service delivery process. The workgroup will focus on 24 hour backup plan services, incident management, and risk mitigation quality issues. The workgroup will additionally review overall MFP service delivery quality throughout the grant period.

Quality Assurance Goals

The goals established by the MFP Grant Stakeholders Committee include:

1. Implement the newly designed crisis intervention team process to support HCBS recipients

2. Implement the newly designed standardized web based assessment for nursing facility consumers to evaluate their eligibility and needs.

3. Implement the MFP incident/risk management plan for all persons transitioning.

4. Implement 24-hour back-up services for persons transitioning.

5. Implement the newly developed person centered planning process that addresses risk factors that have been identified in the assessment process and outlines mitigation strategies for persons transitioning from a nursing facility. This plan will be a comprehensive plan that will also outline the client specific 24 hr backup system, service needs, referrals, and consumer choices.

6. Implement newly designed planning process for Developmental Center and ICF/MR transitions that addresses risk factors that have been identified in the assessment process and outlines mitigation strategies and outlines the client specific 24 hr backup plans.

Targeting Process

North Dakota will develop a nursing facility transition coordinator (TC) service to act as a single access point for development and coordination of an individual's transition plan from the nursing facility to the community. ND has identified the Centers for Independent Living (CIL) as the single access point for transitioning from a nursing facility to a qualified residence.

Medicaid eligible individuals with physical disabilities or who are elderly, or who have a developmental disability , that have resided in a nursing facility for a minimum of six months, and are Medicaid eligible for thirty days immediately prior to transition will be targeted for transition to the community.

The most recent MDS on file in the Department's database will be used to first identify Medicaid individuals who meet the minimum six-month institutional requirement, have expressed a desire to return to the community, and are not severely impaired in cognitive skills for decision making and do not have a diagnosis of Alzheimer's. Once identified, information on all individuals will be forwarded to the TC and to the Nursing Facility Social Services Department. A TC and the Nursing Facility Social Worker/designee will then interview individuals to determine if transitioning is desired by an individual and to assess the potential

for transitioning the individual to his or her desired community based on available informal and formal resources and supports available in the community. In addition, any Medicaid eligible individual can self-refer to a TC if they meet the level of care and minimum 6-month occupancy criteria and intend to move to a qualified residence. Referrals will also be encouraged from family members, other agencies, and nursing facility professionals.

North Dakota has developed a discharge-planning model to identify eligible consumers at the state operated institution (Developmental Center) for persons with developmental disabilities. In general, no person is under commitment to the Developmental Center, as residence is a voluntary decision of the person and/or legal decision-maker (such as guardian, which includes annual judicial oversight). The preferences of the person and recommendations of state professionals are used to guide priorities for discharge planning.

For individuals residing in small, community-based intermediate care facilities for the mentally retarded, North Dakota utilizes a referral process whereby consumers and families, working with their DD case manager, have an opportunity to make informed decisions regarding the provision of services and supports.

Waiver Assurances

Enhanced strategies for Money Follows the Person Grant:

- A data base will be developed to maintain the number of referrals made to the grant, time span between referral and transition
- Records will be maintained documenting transitions, length of transition, re-institutionalizations
- Records will be maintained of payment history review of approved supplemental services and transitional care services. If findings are identified a resolution plan will be identified.
- Records of contacts made to the Crisis intervention team and outcomes of the results of the team's process will be recorded and evaluated.
- Nursing Facility Independent Living plans will be reviewed by the MFP Grant Manager. Checklist will be developed that outlines the essential requirements of the plan which need to be met prior to transition. See attachment B.8-K

Level of Care Determination

The state has a contract with the agency DDM-Ascend to approve nursing facility level of care determinations based on the information submitted to them by a case manager or other professional. This contract is monitored by a Medical Services Program Administrator. The level of care instrument used by the state to evaluate and reevaluate whether an individual needs services through the MFP demonstration grant or a waiver is entitled the Level of Care Determination form. The completed document must be approved by DDM-Ascend to verify that the individual meets nursing facility level of care, as defined in ND Administrative Code (N.D. A.C. 75-02-02-09).

Level of Care Appeals Process

The individual or legal representative may appeal the Level of Care eligibility decision within 30 days of the date of this notification. If the request for a hearing is received by the appeals supervisor within 10 days from the date of this notice, the funding for services may continue until an appeal decision is reached. However, all costs for services received must be paid back if the appeal is upheld. The individual may represent him/herself in an appeal hearing or may use a legal counsel, relative, friend, or other spokesperson. The reason for the appeal must be submitted in writing to:

Appeals Supervisor
North Dakota Department of Human Services
600 East Boulevard Avenue
Bismarck, North Dakota 58505-0250

75-01-03-08.2. Notice of preadmission screening and resident review determinations

1. An individual dissatis□ed with an adverse determination made with regard to the preadmission screening and resident review requirements of 42 U.S.C. 1396r(e)(7)(A) or (B) may request a fair hearing in review of that determination.

2. The right to request a fair hearing under subsection 1 arises upon receipt of a notice under subsection 3.

3. If the department's action in administering preadmission screening and resident review is adverse to an individual, the department shall provide to the individual a written notice which conforms to section 75-01-03-07 and which includes:

a. A statement of the adverse determination;
b. The reason for the adverse determination;
c. The date of the adverse determination; and
d. A statement that 42 U.S.C. 1396r(e)(7) requires the department to make such determinations.
e. For purposes of this section and sections 75-01-03-07 and 75-01-03-09.2:

    i. "Adverse determination" means a determination made in accordance with 42 U.S.C. 1396r(b)(3)(F) or 42 U.S.C. 1396r(e)(7)(B), through the application of section 75-02-02-09, that the individual does not require the level of services provided by a nursing facility or that the individual does or does not require specialized services, but does not mean a determination, made under 42 CFR 483.128, that an individual is not suspected of having mental illness or mental retardation; and
    ii. "Signi□cant change" means:
        1. A signi□cant physical status improvement experienced by a nursing facility resident, such that the resident is more likely to respond to special treatment for that condition or might be considered appropriate for a less restrictive alternative setting;
        2. The presence of a nursing facility resident's mental illness, mental retardation, or condition related to mental retardation, not identi□ed prior to admission, when it later emerges or is discovered;
        3. Exhibition of increased symptoms of mental illness or behavioral problems by a nursing facility resident; or
        4. A circumstance arising if a review resulted in a determination requiring inpatient psychiatric treatment for a nursing facility resident, and an update to that determination is needed to support that individual's admission or readmission to a nursing facility following delivery of psychiatric services.
        5. Preadmission screening and resident review, including determinations of signi□cant change, is undertaken applying professional judgment and standards approved by the department that are consistent with the requirements of 42 CFR part 483, subpart C, and 42 U.S.C. 1396r(f)(8).

Money Follow the Person

Money Follows the Person Nursing Facility Independent Living Plans are required to be reviewed by the Grant Manager. An approved level of care is one of the criteria that will need to be in place prior transition. It will be required that Level of Care screening be completed two weeks prior to the transition to allow for both the completion of the plan and to assure the consumer will continue to meet the level of care following discharge from the nursing facility.

Home and Community Based Services

Level of Care is evaluated as outlined in section H of the approved waiver. One of the primary methods is, on a quarterly basis a report is developed and reviewed to assure annual level of care determinations have been completed on the clients listed in the report.

Developmental Disabilities

The Progress Assessment Review (PAR) is completed for all applicants. It is completed prior to determination of DD Case Management eligibility to assess individual need and supports and also determines whether the individual meets the basic ICF/MR Level of Care criteria. An edit within ASSIST prevents the eligibility determination from being completed unless the PAR has been completed. The regional Developmental Disabilities Case Manager is responsible to complete the Level of Care determination/Case Action Form to document the ICF/MR level of care screening. System generated alerts in the individual electronic DD case management file remind the case manager when the annual level of care determination is due. There is an edit in the ND Medicaid payment system that will not allow payment for waiver services unless a current ICF/MR level of care screening is in the payment system. A query is used to examine 100 percent of waiver participants to determine if the levels of care determinations are current. Three administrators from the department of human services Developmental Disability Services Division are responsible for licensure of Regional Human Service Centers every 2 years. Part of this review includes quality review of the PARs (-level of care determination assessments) to evaluate consistency in application of the PAR items in addition to the query that examines 100 percent of level of care determinations to assure they are current (completed annually) and accurate for individuals receiving waiver services.

ICF/MR Screening Level Review Process

The PAR (which is the assessment for Level of Care) is completed annually. Based on a formula the results indicate screening categories. A sample of all PARs and ICF/MR level of care screenings are reviewed and compared during the human service center licensure process. If errors are discovered the regional human service center must develop a plan of correction and a follow up sample will be examined. If an individual was incorrectly screened the case manager will work with the individual to find alternative funding sources to meet their support needs.

Service Plan

Money Follow the Person

MFP Grant Administrator will review each Nursing Facility Independent Living plan prior to transition and will assure that risks have been identified and mitigation plans have been addressed, that a backup plan has been developed, and consumer needs have been addressed and a HCBS service plan has been developed, SFN 1597 has been signed making sure the client is aware of their right to choose between HCBS and institutional care, and goals have been outlined.

Home and Community Based Services

HCBS evaluates all county case management entities on an annual basis as outlined in section H of the approved waiver and methods include but are not limited to the evaluation of service plans (percentage of plans reviewed depends on the county case load) to assure goals and contingency plans are documented, assure assessments, reassessments, and contacts are completed by policy, care plan lists services applicable to client needs. Files are also reviewed to assure that client has signed an explanation of client choice SFN 1597 which makes the client aware of their right to choose between HCBS and institutional care. If a corrective action is noted in the review process the provider is made aware and must respond.

A summary of the care plans which outline client service needs are documented by the case manager on the SFN 1467 (Individual Care Plan for all HCBS service waiver, sped and ex sped services) and SFN662 (Personal Care Services Plan) are required to be submitted to the DHS within three days of completion. All of these plans are reviewed by an HCBS Program Administrator.

Developmental Disabilities

Service plans are completed annually and must address all participants assessed needs including health and safety risk factors and personal goals either by waiver services or through other means. Quantitative reviews of service plans during the licensure review process looked at not only waiver services but other services regardless of funding source. The needs identified in the PAR and outcomes identified by the consumer were compared to the services in the Case Plan to determine if all needs were addressed. Case managers receive a system generated alert to notify them when annual service plans are due. A query can be run at any time to review 100% of service plans to assure plans are completed within the required timelines. The DD Case Manager must inform the individual and/or the legal representative of the following assurances prior to the development and signing of each ISP. The following rights are listed on the top of each ISP form and the individual and/or legal representative signature on the ISP means that they acknowledge the following:

1. They received a copy of their rights.

2. They have been informed of their right to select institutional services or waiver services (if the ICF/MR level of care is met.) The service listed on the ISP will denote the choice made.

3. They were informed of their right to a choice of service provider(s).

4. They received information regarding their right to appeal.

5. They are in agreement with the services listed on the ISP.

The DD case manager's complete face to face visits with the consumer every 90 days to review outcomes, progress made, and satisfaction with services.

DHS central office DD Division staff is responsible for licensure of regional human service centers DD units every 2 years. Qualitative reviews of the plans are completed at that time by comparing the needs identified in the PAR assessment and outcomes identified by the consumer and the services provided.

Plans are to be completed annually. The DD Division has the ability to run a report from the electronic DD file to query 100% of the consumer plans. This can be run at anytime but is always run and analyzed during the licensure process every 2 years

Qualified Providers

Money Follow the Person

Money Follows the Person will develop a contact that will outline the responsibilities and qualifications for Transition Coordination Services
For supplemental services prior approval will be required before purchase/payment of one time transition costs-Supplemental Services Request Form B.5-A

For the 24-Hour Nursing Call Service a contract will be developed that will outline the responsibilities and qualifications.

Home and Community Based Services

HCBS evaluates Qualified Service Providers as outlined in section H of the approved waivers. Provides are targeted based on irregularities on payment history. Provider records are evaluated to assure that they maintain accurate records, and to assure that providers complete the tasks that have been authorized. All providers are required to reenroll every two years. If a corrective action is noted in the review process the provider is made aware and must respond.

When each county is audited during their annual review, a payment history which includes payments paid to all HCBS clients, a three month payment history is reviewed for payment irregularities. Based on the results of this review purposive selection of providers to be reviewed in detail is determined.

Developmental Disabilities

The Department of Human Services reviews provider licensure applications according to NDAC 75-04-01. Licensure is reviewed annually. State law prohibits purchase of service from providers subject to licensure who are not currently licensed. Required providers must provide evidence of continuing accreditation by The Council. Annually all facility based programs must include current sanitation and fire inspections. Providers must obtain criminal background checks for employees. The North Dakota Community Staff Training Program was initiated in 1983 to meet the training needs of employees who provide supports to individuals with developmental disabilities served by community-based providers. The North Dakota Center for Persons with Disabilities, through a contract with the Disability Services Division, coordinates the training, develops and revises the curriculum, maintains training records, and conducts workshops and conferences. Through a network of 25 regional staff

trainers, the curriculum is delivered on-site and tailored to meet agency and consumer specific needs.

Health and Welfare

Money Follow the Person

Risk Assessment and Mitigation Plan

For persons with a physical disability or an elder
Money Follows the Person has developed nursing facility transition assessment and risk mitigation plan that documents mitigation process for all nursing facility transitions. This plan needs to be reviewed before transition. Following transition, the plan will be reviewed by the Transition Coordinator after all critical incidents, during all planning meetings, and at least once every six months.

The Transition assessment completed by the Transition Coordinator identifies areas of risk that need to be addressed by the consumer's planning team prior to transition. The team will include the consumer, family as appropriate, Transition Coordinator, and the nursing facility discharge planning team. The consumer and the Independent Living Plan Team will review the identified areas of risk and develop risk mitigation strategies to address those risks. The plan will be completed prior to discharge from the institution. The mitigation plan will become a part of the Independent Living Plan. The plan will be developed before transition and will be reviewed by the Transition Coordinator/DD Case Manager and/or the DD provider team following transition after all critical incidents, during all planning meetings, and at least once every six months.

(See Attachment B.8-H)

For persons with a Developmental Disability

For all transitions from an ICF/MR facility a needs assessment will be completed and a risk mitigation plan developed prior to transition to the community. Individual Services Plans and Mitigation Plans will be reviewed by Human Services staff. After transition the plan will be reviewed by planning team and/or the DD Case Manager after all critical incidents, during all planning meetings, and at least once every six months.

The Risk Assessment and Mitigation Plan will be completed by the consumer, parent or legal decision maker if applicable; DD case manager, team members from the "sending" agency (community ICF/MR or Developmental Center) currently providing services and team members from the "receiving" agency (home and community based service provider) who will be providing future

services under the MFP grant. The Plan should be completed 60 days prior to the consumer's move to home and community based services and provided to the receiving Support Coordinator who is responsible to develop the individual person centered plan upon admission to services.

Participants should identify all risk issues that are known or believe to apply to them, briefly describe why the issue currently presents a particular risk to this person or how the issue has presented significant risk in the past. Include a recommended strategy for managing the risk. A full analysis, decisions and plans if needed, will be made around each risk identified at the individual plan meeting held upon admission and reviewed at the 30 day person centered plan following admission to HCBS services. Participants in the 30 day person centered plan will include DDCM, representatives from sending agency team and receiving agency team responsible for plan development and implementation.

The Risk Assessment and Mitigation Plan will be a part of the consumers overall support plan upon transition from the institution. The plan will be developed before transition and will be reviewed by the Transition Coordinator/DD Case Manager and/or the DD provider team following transition after all critical incidents, during all planning meetings, and at least once every six months

(See Attachment B.8-H)

Consent (Rights/Incidents/Appeals Information)

When the Consumer/legal representative has agreed to participate in the MFP grant they will sign consent to participate, will be provided with a copy of the MFP consumer rights brochure, critical incident reporting information, and will be made aware of the appeals process.

Back Up Planning

Consumers and/or their legal representatives will participate in the development of an individualized back-up plan during the transition planning process. All back up plans will include contact information for the 24 hour on call nursing service available to all MFP participants. Information will be specifically provided to the consumer that will include back-up agency phone numbers and contact names.

Individualized back up plan development will be reviewed to assure they address the three levels of back up needed for each consumer as outlined in MFP grant policy. Backup plans will be reviewed after all critical incidents, during all planning meetings, and at least once every six months.

Calls to the 24 hour nursing call service will generate a report that outlines the nature and outcome of each call. The MFP Grant Administrator will track all calls and document the number and type of requests for critical back-up, monitor responsiveness and timeliness of local agencies to consumer calls, and the effectiveness of individual backup plans. The MFP Grant Program Administrator will follow-up with service providers, Transition Coordinators, and Case Managers to address any needed remediation or improvements warranted.

Critical Incidents

Reportable Critical Incidents Defined

1. Abuse
2. Neglect
3. Exploitation
4. Rights Violations
5. Serious Injury
6. Missing Person
7. Death
8. Medical Emergency
9. Restraints
10. Medical Errors
11. Law Enforcement Contact
12. Suicide Attempt

General Definition

A “Critical Incident” is any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety or well being of a Money Follows the Person Grant Participant.

Who is supposed to report a critical incident?

Any person who becomes aware of a critical incident including a consumer is to report a critical incident.

Qualified Service Providers that are enrolled with the Department of Humans Services, Transition Coordinators, and Case Managers, DD providers, DD Case Managers are required to report incidents.

Critical incident reporting for persons transitioning from a nursing facility

Individuals wishing to report an incident can contact any of the following persons:

- Transition Coordinator Name _____
  Address _____
  Phone _____

- Case Manager Name _____
  Agency _____
  Address _____
  Phone Number _____

- Money Follows the Person Grant Manager: Jake Reuter, Department of Humans Services, Medical Services, Department 325, 600 East Boulevard Ave, Bismarck, ND 58505, Phone: 1-800-755-2604

Reporting Process

The critical incidents report form will be completed by the Transitional Coordinator, Case Manager, QSP or the Money Follows the Persons Grant Program Manager. Reports will be forwarded to the MFP Program Administrator within three days of the incident. The MFP Program Administrator will respond to the Incident within 10 days of the initial

report. Action will be taken to resolve the concerns and a follow-up plan will be developed by the MFP Program Administrator. Incidents should also be reported to other agencies or entities as policy, law, regulation, or the situation requires- See HCBS Abuse reporting process guidelines listed below.

Review

Critical Incident reports will be completed by the Transition Coordinator, QSP, or the HCBS Case Manger and forwarded to the MFP Grant Program Administrator for processing. MFP Administrator will respond to each incident based on need and significance within 10 days of each report. Copies of all incident reports will be maintained in the MFP participants file and tracked within a quality data base as part of the MFP Quality Assurance process.

Developmental Disabilities Community providers use an agency specific incident reporting document and management process that addresses each of the ten critical incidents defined above. Critical incidents are reviewed and tracked by the Developmental Disabilities Division. Attachment: B.8-L Protection and Advocacy Reporting Guidelines B.8-M and DDD-006 Response to Reports of Alleged Incidents of Abuse, Neglect, or Exploitation outline the processes within the Developmental Disabilities System.

HCBS Abuse Reporting Process

A. Monitoring for Abuse, Neglect, or Exploitation: When completing monitoring tasks if the case manager suspects a Qualified Service Provider or other individual is abusing, neglecting, or exploiting a recipient of HCBS the following protocol is to be followed by the HCBS Case Manager.

B. In all situations:

    a. Notify the Program Administrator responsible for complaint resolution in writing of all actions taken to follow up on a suspected case of abuse, neglect, or exploitation of an HCBS recipient.

        - Identify and document in writing the name of the recipient.
        - Identify and document in writing the name of the qualified service provider or other individual.
        - Document in writing a complete description of the problem or complaint.

- Immediately report suspected physical abuse or criminal activity to law enforcement.
- If you have reasonable grounds to believe the recipient's health or safety is at immediate risk of harm, make a home visit to further assess the situation and take whatever action is appropriate to protect the recipient.
- If you can document that no immediate risk exists, but a problem requires further action, work with the recipient and other interested parties to resolve the matter as soon as possible.
- If the HCBS Case Manager and Nurse Manager/Trainer determine that an incident is indicative of abuse, neglect, or exploitation, the HCBS Case Manager must immediately report the incident to the Department.
- Comply with North Dakota State law Chapter 50-25.1, CHILD ABUSE AND NEGLECT.

C. Monitoring for Abuse, Neglect, or Exploitation specific to the client's living arrangements, individuals implicated, or the Provider type.

D. Notify the Program Administrator responsible for complaint resolution in writing of all actions taken to follow up on a suspected case of abuse, neglect, or exploitation of a HCBS recipient.

- If Client lives in his or her own home and the qualified service provider is an Individual or Agency enrolled QSP:
- If you can document that no immediate risk exists, but a problem requires further action, work with the recipient and other interested parties to resolve the matter as soon as possible.
- If the qualified service provider is an Assisted Living Facility:
  - Notify the Aging Services Division Ombudsman Program Administrator and the DHS Program Administrator responsible for Assisted Living Licensing.
- If the complaint involves the provision of home delivered meals, contact the HCBS Program Administrator.
- Client lives in his or her own home and is being abused, exploited, or neglected by an individual other than the QSP:
  - File a report with law enforcement and/or Adult Protective Services as indicated by the seriousness of the allegation.
- If the client is living in a AFFC Home:

- Contact the CSSB responsible for AFFC licensing, the appropriate human service center staff responsible for compliance of licensing regulations for AFFC and the Medical Services Division Adult Family Foster Care Service Program Administrator, and the Aging Services Division Adult Family Foster Care Licensing Program Administrator.

- If the case involves a Licensed Child Foster Care Home, the regional representative responsible for the children's foster care licensing must be contacted.
- If the client is receiving services through the DD/MR Waiver, see Section within HCBS Case management-Service to DD/MR Population.
- When the service is provided on Reservation Lands, the Tribal Laws that govern abuse and neglect on that reservation must be followed.

E. The Department of Human Services may remove a Qualified Service Provider from the list of approved providers if the seriousness and nature of the complaint warrants such action. The Department will terminate the provider agreement with a Qualified Service Provider who performs substandard care, fraudulent billing practices, abuse, neglect, or exploitation of a recipient. North Dakota Administrative Code section 75-03-23-08 lists reasons why the Department may terminate a Qualified Service Provider.

Critical Incidents Definitions

1. Abuse

a. Willful use of offensive, abusive, or demeaning language by a caretaker that causes mental anguish of any person with developmental disabilities;
b. Knowing, reckless, or intentional acts or failures to act which cause injury or death to a developmentally disabled or mentally ill person or which placed that person at risk of injury or death;
c. Rape or sexual assault of a developmentally disabled or mentally ill person;
d. Corporal punishment or striking of a developmentally disabled or mentally ill person;
e. Unauthorized use or the use of excessive force in the placement of bodily restraints on a developmentally disabled or mentally ill person; and

f. Use of bodily or chemical restraints on a developmentally disabled or mentally ill person which is not in compliance with federal or state laws and administrative regulations.

2. Exploitation

An act committed by a caretaker or relative of, or any person in a fiduciary relationship with, a person with a disability, means:

a. The taking or misuse of property or resources of a person with developmental disabilities or mental illness by means of undue influence, breach of fiduciary relationship, deception, harassment, criminal coercion, theft, or other unlawful or improper means;
b. The use of the services of a person with developmental disabilities or mental illness without just compensation; or
c. The use of a person with developmental disabilities or mental illness for the entertainment or sexual gratification of others under circumstances that cause degradation, humiliation, or mental anguish to the person with developmental disabilities or mental illness.

3. Neglect

a. Inability of a person with disabilities to provide food, shelter, clothing, health care, or services necessary to maintain the mental and physical health of that person;
b. Failure by any caretaker of a person with developmental disabilities or mental illness to meet, either by commission or omission, any statutory obligation, court order, administrative rule or regulation, policy, procedure, or minimally accepted standard for care of persons with developmental disabilities or mental illnesses;
c. Negligent act or omission by any caretaker which causes injury or death to a person with developmental disabilities or mental illness or which places that person at risk of injury or death;
d. Failure by any caretaker, who is required by law or administrative rule, to establish or carry out an appropriate individual program or treatment plan for a person with developmental disabilities or mental illness;
e. Failure by any caretaker to provide adequate nutrition, clothing, or health care to a person with developmental disabilities or mental illness;
f. Failure by any caretaker to provide a safe environment for a person with developmental disabilities or mental illness; and

g. Failure by any caretaker to provide adequate numbers of appropriately trained staff in its provision of care and services for persons with developmental disabilities or mental illnesses.

4. Rights Violations

Through omission or commission, the failure to comply with the rights to which an individual with a disability is entitled as established by law, rule, regulation, or policy.

5. Serious Injury

Reported, regardless of the cause or setting in which it occurred, when an individual sustains:

- A fracture
- A dislocation of any joint
- An internal injury
- A contusion larger than 2.5 inches in diameter
- Any other injury determined to be serious by a physician, physician assistant, registered nurse, licensed vocational nurse/licensed practical nurse.

6. Missing Person

Whenever there is police contact regarding a missing person regardless of the amount of time the person was missing

- During a period of time in which a program provider is responsible for supervision of program participant/consumer.

- Not During a period of time in which a program provider is responsible for supervision of program participant/consumer.

7. Death

The death of an individual is reported, regardless of the cause or setting in which it occurred.

- During a period of time in which a program provider is responsible for supervision of program participant/consumer.

- Not During a period of time in which a program provider is responsible for supervision of program participant/consumer.

8. Medical & Psychiatric Emergency

Admission of an individual to a hospital or psychiatric facility or the provision of emergency medical services (treatment by EMS) that results in medical care which is unanticipated and/or unscheduled for the individual and which would not routinely be provided by a primary care provider.

Use Of:

- Emergency Medical Services (example*: emergency room care)
- Emergency Psychiatric Services (example*: mental health facility admission)
- Life Saving Intervention (example*: Heimlich, CPR) – * Example is just one of several possible scenarios

9. Restraints

Every time an individual is restrained

- Personal (the application of pressure, except physical guidance or prompting of brief duration, that restricts the free movement of part or all of an individual's body)
- Mechanical (the use of a device that restricts the free movement of part or all of an individual's body. Such devise includes an anklet, a wristlet, a camisole, a helmet with fasteners, a muff with fasteners, a mitt with fasteners, a posey, a waist strap, a head strap, and restraining sheet. Such a device does not include one used to provide support for functional body position or proper balance, such as a wheelchair belt or one used for medical treatment, such as a helmet used to prevent injury during a seizure.) It also means to cause a device that allows for free movement to be useable. Such as locking a wheelchair or not allowing an individual access to technology.
- Chemical (the use of a chemical, including a pharmaceutical, through topical application, oral administration, injection, or other means to control an individual's activity and which is not a

standard treatment for the individual's medical or psychiatric condition).

- o Included In A Written And Approved Behavior Plan
- o Not Included In a Written and Approved Behavior Plan
- o Seclusion: involuntary confinement in a room that the person is physically prevented from leaving.
- o Isolation: forced separation or failure to include the person in the social surroundings of the setting or community.

10. Medication Discrepancy

When there is a discrepancy between what a physician prescribes and what an individual actually takes and the individual self-administers medication under supervision of the Program Provider or has medication administered by the Program Provider. A medication discrepancy is when one or more of the following occurs:

a. Wrong medication: an individual takes medication that is not prescribed for that individual. This includes taking medication after it has been discontinued or taking the incorrect medication because it was improperly labeled.

b. Wrong dose: An individual takes a dose of medication other than the dose that was prescribed.

c. Omitted dose: An individual does not take a prescribed dose of medication within the 24-hour period of a calendar day. An omitted dose does not include an individual's refusal to take medication.

d. Dose Refused: An individual's refusal to take medication resulting in a medical emergency or use of restraint

11. Law Enforcement Contact

A person receiving services is charged with a crime or is the subject of a police investigation, which may lead to criminal charges; an individual is a victim of a crime against the person; crisis intervention involving police or law enforcement personnel.

12. Suicide Attempt

The intentional attempt to take one's own life. A suicide attempt is limited to the actual occurrence of an act and does not include verbal suicidal threats by a person receiving services.

Home and Community Based Services

Face to face client interviews as outlined in section H of the approved waiver are completed. Clients receiving services under the Medicaid waiver are targeted. Some of the questions included in the interview include was the client offered a choice of providers, is the client aware that they can change providers, does the provider complete all tasks approved, meets their needs, meets their expectations, is the provider considerate and conscientious. If a finding is noted in the interview the case manager or appropriate contact is made to resolve the finding. HCBS policy outlines abuse/neglect/exploitation policy and maintains a data base documenting reported cases of abuse/neglect/exploitation or complaints and there resolution. Response timeline is outlined in the approved HCBS Section H.

Developmental Disabilities

- DD Case Mangers visit waiver recipients on a face to face basis each quarter to review appropriate services, consumer satisfaction, identify barriers to service, address abuse or neglect concerns, and follow-up on previously identified issues.
- During the initial licensure process, provider policies and procedures are reviewed by DD Division staff to assure they address the requirements to report and investigate all incidents of abuse, neglect and exploitation. DD Division staff and the Protection and Advocacy Project conduct a historical review of incident reports and monitor implementation of abuse, neglect and exploitation policies and conduct refresher training and follow up with all licensed DD providers every two years. Policy DDD-PI-006 is the Department of Human Services Policy and Procedure that addresses responses to reports of alleged incidents of abuse, neglect, or exploitation of individuals receiving developmental disabilities services from licensed DD providers. (See Attachment B.8-M)

- The DD Division maintains a data base of protective service reports.

A. Administrative Authority

Money Follow the Person

The Department of Human Services, Medical Services Division will develop a contract with the On call nursing services agency and the four Centers for Independent Living to include clearly defined roles and responsibilities, standardized policies, procedures, system performance standards, and practice guidelines. The grant manager will be responsible to monitor the contract and quality of service provider by the contractor.

Home and Community Based Services

HCBS evaluates all county case management entities on an annual basis as outlined in section H of the approved waiver. The Department of Human Services has a signed Memorandum of Understanding that outlines responsibilities with all County Social Service Boards.

Developmental Disabilities

The North Dakota Department of Human Services is the single state Medicaid agency which includes the DD Division and Medical Services. Waiver coordination meetings are held quarterly between Medical Services and units administering waivers. The DD Division is responsible for licensure of the eight regional DD case management units and all DD providers.

B. Financial Accountability

Money Follow the Person

The MFP Grant Administrator will prior approve all supplemental services requests. The grant manager and DHS Fiscal Representative will reconcile approved services with payment histories. Grant manager will randomly conduct a review to reconcile the transitional care coordination service history with time documented on the web based transitional assessment.

On Call Nursing Service costs will be monitored by the MFP Grant Program Administrator and DHS Fiscal Representative based on the contract agreement for service payments. Numbers of call reports and

billing history will be monitored to assure proper billing processes are being followed.

Home and Community Based Services

HCBS evaluates all Qualified Service Providers as outlined in section H of the approved waivers. Provides are targeted based on irregularities on payment history. The providers documentation is reviewed to assure that provider documentation correlates with payment history, provider bills at the agreed upon rate, that they use the correct procedure code, and bill within the approved amount authorized by the case management entity. If a corrective action is noted in the review process the provider is made aware and must respond. If the provider does not respond or a pattern of inaccurate billing is noted, it could result in the provider's enrollment status being terminated.

When each county is audited during their annual review, a payment history which includes payments paid to all HCBS clients, a three month payment history is reviewed for payment irregularities. Based on the results of this review purposive selection of providers to be reviewed in detail is determined.

Developmental Disabilities

DD Case managers determine Level of Care as a prerequisite for waiver services. Case mangers then authorize services on the individual service plan in ASSIST. Edits are built into the system to prevent payment for services not authorized. The DD claims reviewer receives weekly queries of ASSIST data for individual changes to level of care and start or termination of waiver services which is entered in the Medicaid payment system.

Attachments

Appendix B.8 Quality

B.8-A Transition Assessment
B.8-B Independent Living Plan which includes risk mitigation plan/24 hour backup
B.8- C Developmental Disabilities Individual Service Plan
B.8-D Developmental Disabilities Progress Assessment Review (PAR)
B.8-E Resident Decision Profile
B. 8-F Notification of Denial, Termination, or Reduction in Service Form

B.8-H Risk assessment and Mitigation Policy and NF and DD forms
B.8- I 24-backup Planning Policy and Back-up Plan
B.8-J Critical Incident Reporting and Management Policy
B.8-K Checklist for the Independent Living Plan
B.8-L Protection and Advocacy Reporting Guidelines
B.8-M DDD-006-Response to Reports of Alleged Incidents of Abuse, Neglect, or Exploitation of Individuals Receiving Developmental Disabilities Services from Licensed DD Providers

B.9 Housing

The Money Follows the Persons housing goal is to implement strategies that will address the need to develop affordable, accessible, and available housing in North Dakota for MFP recipients as well as for other individuals with a disability. These strategies will be the basis for the actions of the Housing Workgroup and the Stakeholder Committee during the grant period.

Definition of qualified residences for MFP participants

A home owned or leased by the individual or the individual's family member;
An apartment with an individual lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control; and
A residence, in a community-based residential setting, in which no more than 4 unrelated individuals reside i.e. Adult Family Foster Care or Community Group Home

Description of the State Regulations for Each Type of Housing

Adult Family Foster Care (AFFC)

An occupied private residence in which adult family foster care is regularly provided by the owner or lessee thereof to four or fewer adults who are not related by blood or marriage to the owner or lessee, for hire or compensation.

Adult Family Foster Care must meet State regulation as outlined in the "Qualified Service Provider Handbook"- Adult Family Foster Care Provider, Individual Qualified Service Provider, and AFFC Respite Provider including standards for practice and enrollment procedures as issued 5/2007 by:

> Aging Services Division; N.D. Department of Human Services; 600 E Boulevard Ave, Dept 325; Bismarck, ND 58505-025; at the following website:
> http://www.nd.gov/dhs/info/pubs/docs/aging/handbook-for-qsp.pdf
> and in the State Adult Foster Care Policy Manual at:
> http://www.state.nd.us/robo/projects/66005/66005.htm

Developmental Disabilities Residential Options

All ND community providers must be licensed to provide services. This specifically means authorization by the Department of Human Services to provide a service to individuals with developmental disabilities, pursuant to North Dakota Century Code chapter 25-16 and as outlined in ND Administrative Code found at http://www.legis.nd.gov/information/acdata/pdf/75-04-01.pdf

The department also adopted and made a part of its administrative rules for all licensees the current standards used for accreditation by the council on quality and leadership in supports for people with disabilities. If a licensee fails to meet an accreditation standard, the department may analyze the licensee's failure using the appropriate 1990 standards of the council on quality and leadership in support for people with disabilities.

The following developmental disabilities services will generally be used as a qualified MFP Residence or to support and MFP participant in the community:

1. **Individualized supported living arrangements** – means residential support services options in which services are contracted for a client based on individualized needs resulting in an individualized rate setting process and are provided to a client in a residence rented or owned by the client.

2. **Family support services** – means a family-centered support service contracted for a client based on the primary caregiver's need for support in meeting the health, developmental, and safety needs of the client in order for the client to remain in an appropriate home environment.

3. **Minimally supervised living arrangements** means either – a group home with an available client adviser; or a community complex that provides self-contained rented units with an available client adviser.

4. **Transitional community living facility –** means a residence for clients with individualized programs consisting of social, community integration, and daily living skills development preliminary to entry into less restrictive settings.

5. **Home or Apartment –** The regulations relevant to an apartment/home would be the Housing Quality Standards (HQS). The HQS are Housing and Urban Development (HUD) standards. The HQS are used by the public housing authorities when they evaluate homes or apartments that are going to be rented by an individual with a housing voucher. Every residence is assessed and the results are documented and retained in the persons housing file.

Apartments/homes are reassessed on a regular basis to assure that it continues to meet standards. Only residences that meet these standards are eligible for use with a voucher.

Housing offices utilize a checklist for the assessment process. The HQS assessment checklist could be used to assure that a residence that is not subject to HUD regulation is evaluated by the professional involved with the transition. Training for this process could be provided by a housing office staff member if this situation would develop. The HQS checklist comes with instructions. This would come into play when someone moves to a private home that they own or is owned by a family member and no housing program is assisting with the housing costs.

The HQS would be applied in a reasonable fashion if used to assess a privately owned family home. The intent would not be to prevent the move but to address any real life safety issues. The need to negotiate for the welfare needs of the individual would assure that the home meets minimal standards and reasonable accommodations are made for the person moving to the home. If a concern had no impact on the person with a disability it would not be appropriate to make this a road block for the move. Example: No vent or window in older home's bathroom.

All buildings need to meet minimal building code requirements such as sewer, water, electrical codes. The additional HQS could be applied to privately owned homes beyond those standards to assure an appropriate and safe living environment. The ultimate goal is to assure a good quality of life for each person.

Housing Quality Standards address the Americans with Disabilities Act (ADA) reasonable accommodations requirements. Fair housing laws require that landlords allow renters to make their own reasonable accommodations as long as they return the apartment to its prior condition.

Document Requirements for all Residences into which Money Follows the Person Participants are Placed to Assure They Meet Money Follows the Person Statutory Definitions for "Qualified Residences"

The Transition Coordinator will document in a computerized assessment the type of qualifying residence that the nursing facility MFP participant transitions to after discharge from the institution. The system will require the Transition Coordinator to record the type of qualifying residence that will be utilized. The Transition Coordinator will be provided with the necessary training to determine if the residence meets MFP specifications. The system is a nationally recognized

software program entitled “SAMS” and will be monitored by the MFP Grant Program Manager as part of the MFP quality assurance strategy.

The Developmental Disabilities Case Manager will document on the MFP Form the type of qualifying residence that the Developmental Center or community ICF/MR MFP participant transitions to after discharge from the institution. The DD Case Manager will be required to record the type of qualifying residence that will be utilized. The DD Case Manager will be provided with the training necessary to determine if the residence meets MFP specifications as a qualified residence.

Project Based Housing Resources

North Dakota has 130 HUD Section 8 properties with a total of 3,398 units. There are 26 HUD Moderate Rehabilitation Properties with 378 total units in the State. Currently, there are 126 Low Income Housing Tax Credit Properties with 3,678 total units. The HOME Investment Partnership Program has 58 properties with 1,214 units. North Dakota also has 188 United States Department of Agriculture Rural Development Projects funded for a total of 2,700 units.

All Transition Coordinator providers have been provided with a listing of the project have been provided with a listing of the project based housing resources in North Dakota including contact information for specific sites. This information will assist the Transition Coordinators in locating the available housing options for the consumers that they are assisting consumers with transition.

The Money Follows the Person Stakeholder Housing Workgroup will request that the State’s Low Income Housing Tax Credit (LIHTC) Program Qualified Allocation Plan (QAP) provide additional incentive for multi-family development and rehabilitation projects with set asides for the elderly and/or disabled. The State’s plan, which is administered by the NDHFA, currently provides points in its scoring system for units targeted for the elderly and disabled. We will ask NDHFA to add points for this population group starting in the Fall of 2008 for inclusion in the 2009 Qualified Allocation Plan. This strategy will continue to be pursued each Fall for the following year’s QAP.

The Money Follows the Person Housing Workgroup is supporting and participating in the development of a North Dakota Housing Trust Fund. This has been identified as a long-term strategy to support the development of statewide affordable, accessible, and available housing. The Housing Workgroup is working in cooperation with other groups around the State for the purpose of introducing legislation to establish a trust fund during the 2009 Legislative Session.

Tenant Based Housing Resources

North Dakota has established 32 Public Housing Authority (PHA) offices around the state to serve persons in need of assistance with their housing needs. North Dakota has 7,479 tenant based vouchers at this time. In 2007, these PHA offices issued 6.900 Housing Choice Vouchers resulting in approximately $25.1 million in Housing Assistance Payments (HAP). The Public Housing Authority Offices hope to avoid any federal decrease in the number of housing vouchers provided at this time. If the North Dakota Housing Trust Fund is approved, efforts will be made to develop gap services to address the waiting lists for housing vouchers in the metropolitan areas of the State.

The Money Follows the Person Housing Workgroup is supporting the development of local preferences for persons transitioning with each of the individual Public Housing Authority offices in the State. North Dakota Housing Authorities have been asked to consider Money Follows the Person participants as a local priority to the extent possible. A letter and Money Follows the Person brochure has been sent to each of the PHA Executive Directors explaining the Money Follows the Person Grant, and the needs of the consumers participating in grant services. A meeting has been requested with the Executive Directors to review and discuss the request for the establishment of the prioritizing Money Follows the Person participants. Currently, each PHA office is considering the MFP priority on an individual basis.

Strategies to assure a sufficient supply of qualified residences and to assure Money Follows the Person participants have a choice among them.

1. The MFP Stakeholder Committee has established a Housing Workgroup that includes representatives from the North Dakota Housing Finance Agency (NDHFA), the Department of Commerce, Division of Community Services; ND Community Action agencies; Public Housing Authorities (PHA); the Housing Program Director of CommunityWorks of North Dakota; Protection and Advocacy of ND; Center of Independent Living Staff; a provider of Assisted Living services; IPAT representative; the MFP Grant Program Manager; and a member of the Medicaid Infrastructure Grant (MIG) Housing Task Force. This group is representative of all the primary housing agencies in North Dakota and will continue to meet throughout the grant period to facilitate cooperative efforts to provide integrated, affordable, and accessible community housing options.

2. The MFP Housing Workgroup will work to develop local preferences for persons transitioning with each of the individual PHA offices in the State. This will involve communicating the goals of MFP and making the request that PHAs address the issue of establishing a local MFP priority.

The directive from the HUD Secretary will be used as part of the communication with the PHAs as he has specifically encouraged PHAs to set local preferences, and to use public housing units, Housing Choice Vouchers, and Mainstream Vouchers to support people with disabilities in their transition to the community.

3. The primary provider of housing in North Dakota will be either section 8 project based or voucher based assistance. Once again this strategy will involve facilitating communication and collaboration with the ND Public Housing Authorities (PHAs), the NDHFA, USDA Rural Development, and the Dept of Commerce to assure an adequate supply of housing. The MFP Housing Workgroup will collaborate with the Medicaid Infrastructure Grant Housing Task Force to accomplish this strategy.

4. A comprehensive list of project based housing available in ND has been developed.

5. NDHFA, USDA Rural Development, and Dept of Commerce project based housing have been identified around the State. A list of these projects that provide restricted access to individuals with some form of a disability has been prepared for use by the professionals assisting with transitions.

6. The list of project based housing would best be managed by the local housing authorities but will be provided to the transitional staff for all population groups to be served by the grant. This process would be effective for all populations in need of housing. The intent is to assure that all local public housing authorities can provide information about all the housing options in their specific area not just voucher related information. The MFP housing workgroup will approach the PHA administrators about accepting this responsibility.

   Address increased use of Section 8 Housing Choice Voucher Homeownership Program assistance.

7. At this time only two agencies are utilizing this option including Grand Forks and Fargo. This strategy is a good long term goal to pursue but it will have to be addressed individually with each local housing agency to determine if they have the capacity to manage the large amount of paperwork that goes with each case.

8. Contact the ND Builders Association to discuss incentives that would encourage voluntary development of more accessible housing.

   Provide education so that builders construct projects that allow individuals to “Age in Place”.

9. Request that the State's Low Income Housing Tax Credit (LIHTC) Program Qualified Allocation Plan provide additional incentive for multifamily development and rehabilitation projects with set asides for the elderly and/or disabled.

10. The state's plan, which is administered by the NDHFA, currently provides points in its scoring system for units targeted for the elderly and disabled. We will ask that they add additional points for this targeting.

11. Assisted living was also noted as a housing option that has been identified. LIHTC have been of question as it has been difficult to separate the housing and services components. Services must be optional. NDHFA will be encouraged to create LIHTC scoring incentives for the development of assisted living facilities.

12. Several funding sources exist for housing rehabilitation current housing. There are programs provided by NDHFA, USDA Rural Development, and through HUD's HOME program. Program s include Helping HANDS, RAP, 504 Rural Development Loans and Grants, HOME and CDBG programs, to name a few. Each program has funding limitations and eligibility issues.

    The workgroup will contact the seven Community Action Program (CAP) regional offices to see if they would act as the primary contact for housing rehab needs. If they could not help with the programs they administer, they could refer to others. This would require some education for the CAP caseworkers if this were to work well.

13. The need to be flexible in determining what is going to work was emphasized as strategies that may work in the larger cities may not work in the more rural areas of the state.

14. The MIG housing taskforce is pressing for legislation that would require new construction to meet visit-ability standard at both the national and state level. The MFP workgroup has discussed this issue and the cultural issues around this being "required by law" for private housing projects. It is noted that providing incentives and working on long term culture change to encourage this action is of great value and the approach recommended by the MFP housing workgroup.

15. The development of a ND Housing Trust Fund has been identified as a long-term strategy to support the development of affordable, accessible, and available housing. The Housing Workgroup will work to support the development of the fund in cooperation with other groups around the state.

16. Other Potential strategies or housing related issues:

    a. First time homebuyer's loans could be utilized for MFP and other individuals
    b. Concerns about high taxes for the elderly in their home could be addressed with reverse equity mortgages, Homestead and disabled tax credits (state would reimburse the county for this credit).

17. Private apartment units can be identified through local MLS or apartment association but many would likely not be affordable without a Section 8 housing voucher.

18. Many nursing facilities have independent living units/apartments as part of their building. We will develop a list with assistance from the LTC Association
19. Assisted Living continues to be an appropriate MFP housing option but cost remains the primary issue. Efforts will be made to evaluate what other states are doing to utilize assisted living facilities.

Resources

North Dakota Department of Commerce

The Department of Commerce administers the Home Investment Partnerships (HOME) Program through various sub recipients including the seven Regional Community Action Agencies, two Community Housing Development Organizations (CHDOs), and the cities of Grand Forks and Bismarck. All HOME funds are restricted to benefiting low-income persons.

The Community Action Agencies utilize HOME funds to perform single-family home rehabilitation work for low-income homeowners. In addition, the agencies also receive LIHEAP funds through the ND Department of Human Services and from the US Department of Energy (DOE) for its weatherization program for low-income homeowners.

The two CHDOs, Affordable Housing Developers Inc., which covers the western half of the state, and the Eastern Dakota Housing Alliance, covering the eastern half of the state, utilize HOME funds to participate in the development and rehabilitation of multi-family apartment structures. The CHDOs are also eligible to provide homeownership assistance.

As entitlement cities, Grand Forks and Bismarck receive HOME allocations annually. They are eligible to participate in any HOME-eligible activities as long as the activity is consistent with their city's Consolidated

Plan and the state HOME Program. The cities have recently been involved in the development of multi-family properties for the general population, as well as special needs populations such as transitional housing and housing for the developmentally disabled.

NDHFA can target some first time home buyer money-do not have to be 1st time buyer and can use 40 year mortgage

Home of Your Own

These funds have not been utilized at any significant level at this time

Home Choice-Non-Conventional Loan options for purchase of housing (CommunityWorks)

Utilize Habitat for Humanity housing options

Utilize Veterans Loans and related service

"Funding Sources Successfully Used by States to Support Development of Integrated, Affordable, and Accessible Community Housing" – this publications was issued in November of 2007 and will be utilized as a tool by the MFP Housing Workgroup to develop new housing strategies throughout the grant period. All workgroup members have been provided a copy for their review.

The ND MIG Housing Task Force has also created an informational housing manual that provides all persons with information on public assistance for housing, a review of the Homeownership programs, a review of property tax exemptions, a discussion of assistive technology and home modifications, a review of how to finance home modifications, an outline of housing rights and accessibility laws, and a listing of community resources. The manual is titled *"The Perfect Home: Resources and Options for People with Disabilities"* This manual will be provided to the Transition Coordinators for use in finding housing in their specific area of the State.

Definitions

The need to define what the group views as housing was discussed without a formal definition being finalized. Some of the concept definitions offered in the new housing document were provided for increased understanding and clarification.

Universal Design – 'The design of products and environments to be usable by all people, to the greatest extent possible, without the need for adaptation or specialized design.' (Center for Universal Design, North Carolina State University at: http://www.design.ncsu.edu/cud/about_ud/about_ud.htm

Accessible - Accessible design generally refers to houses or other dwellings that meet specific requirements for accessibility. For example: building codes, housing regulations, and guidelines.

Adaptable – Adaptable design allows some features of a building or dwelling to be changed to address the needs of an individual with a disability or a person encountering mobility limitations as he/she ages. Such design features allow the change to be made quickly…without the use of skilled labor and without changing the inherent structure of the materials.

Visit-able – Visit-able refers to homes that are not only accessible to guests with disabilities visiting the homes of non-disabled hosts, but to the future needs of the non-disabled residents as well. Access features include zero-step entrances, accessible hallways, and accessible bathroom

B. 10 Continuity of Care Post Demonstration

Nursing Facility Transitions

With the exception of demonstration/supplemental services for the transition and supplemental demonstration services for deposits, furnishings, and vehicle modifications, all home and community-based waivered services and all state plan services provided as MFP demonstration services that were available to an individual in the first year following transition from the nursing facility will be available in subsequent years of the demonstration program contingent upon program eligibility requirements. The ND Home and Community Based Services waiver has the slot capacity to accept the increased number of applicants anticipated through this project, with the assumption that each new program participant will continue to be served by the respective waiver after the end of the first year of community based service provision.

The county case manager will complete a level of care screening within the last 60 days of a MFP participant's 365 days of eligibility to determine waiver eligibility at time of MFP discharge. If a MFP participant no longer meets nursing facility level of care screening requirements other service programs will be offered to meet their needs including the ND Service Payments to the Elderly and Disabled and Expanded Service Payments to the Elderly and Disabled, and Older Americans Act Services.

Home and Community Based Services Waiver Services available to persons with a physical disability or an elder after MFP discharge

- HCBS Waiver

  This waiver helps eligible individuals who would otherwise require nursing home services to remain in their homes or communities. It gives eligible people options, if their needs can be met in their homes.

- Technology Dependent Waiver

  This waiver provides attendant care service and case management

- Medically Fragile Children Waiver

  This waiver provides In-Home Supports, Institutional Respite, Transportation, Equipment and Supplies, Individual and Family Counseling, Nutrition Supplements, Environmental Modifications

- Medicaid State Plan-Personal Care (MSP-PC)

Service Payments for the Elderly and Disabled (SPED)

The SPED program provides services for people who are older or physically disabled and who have difficulty completing tasks that enable them to live independently at home.

Expanded Services Payments for the Elderly and Disabled (Ex-SPED)

The Expanded-SPED program pays for in-home and community-based services for people who would otherwise receive care in a licensed basic care facility.

Older Americans Act Services

The Older Americans Act of 1965 (OAA) was enacted to improve the lives of America's older individuals in relation to income, health, housing, employment, long-term care, retirement, and community service. The underlying purpose is to enhance the ability of older individuals to maintain as much independence as possible and to remain in their own homes and communities. Federal funds are allocated to states on an annual basis to provide services to older individuals.

Eligibility Requirements

- Older Americans Act Services are available to individuals who are age 60 and older. There is no means test. Individuals must be given the opportunity to contribute to the cost of the service; however, no one can be denied service due to inability or unwillingness to contribute.

Services Available

- Congregate Meals, Provides nutritional meals in a group setting
- Escort Shopping Assistance, Provides personally assistance to help people with physical or cognitive difficulties to obtain services outside the home environment
- Family Caregiver Support Program, Provides support services to informal caregivers and older adults caring for children 18 and younger
- Health Maintenance, Provides monitoring and screening services for early detection of health issues, and also provides health education, referral and follow-up
- Home Delivered Meals, Provides homebound individuals who are unable to prepare an adequate meal with a nutritious meal

- Legal Assistance, Provides legal advice and representation by an attorney to older individuals with economic or social needs
- Outreach - Includes interventions by an agency or organization for the purpose of identifying potential clients and encouraging their use of existing services and benefits
- Transportation, Provides a method of travel from one specific location to another specific location to access essential community services
- Senior Companion Services, A service that offers periodic companionship and non-medical support by volunteers (who may receive a stipend) to adults with special needs

Services for Persons with a Developmental Disability

North Dakota Developmental Center and Community Intermediate Care Facilities for the Mentally Retarded Transitions

All home and community-based waivered services and all state plan services provided as MFP demonstration services that were available to an individual with a developmental disability in the first year following transition from the Developmental Center or a community ICF/MR will be available in subsequent years of the demonstration program contingent upon program eligibility requirements.

The MR/DD Waiver, Self-Directed Supports for Families waiver, and Self Directed Supports for Adults waiver all have the slot capacity to accept the increased number of applicants anticipated through this project, with the assumption that each new program participant will continue to be served by the respective waiver after the end of the first year of community based service provision.

Within sixty days prior to discharge from the MFP demonstration services an updated level of care screening will be completed by the Developmental Disabilities Case Manager to assure waiver eligibility following MFP demonstration services. Section 11 funded services may be available to MFP participates who no longer meet the ICF level of care. DD Case management services will be continued and if appropriate a referral to alternative Human Service Center services will be initiated.

Qualified home and community-based waivered services available to individuals with a developmental disability following the year they receive services through the demonstration program are:

- MR/DD Waiver
- Self-Directed Supports for Families (Ages 3-21)-
- Self Directed Supports for Adults (Ages 21 and Over)
- And Medicaid State Plan-Personal Care (MSP-PC)

Services that will be available include the following:

- Individualized Supported Living Arrangement (ISLA) – residential service providing support to individuals living in a home owned or leased by the individual.
- Qualified Group Home – community group home or community complex setting which provides training in community integration, social, leisure, and daily living skills to four or fewer unrelated individuals.
- Day Supports – a day program that may include assistance with acquiring, retaining, and improving skills necessary to successfully reside in a community setting.
- Supported Employment Extended Services – supports provided for individuals employed in the community.
- Family Support Services – family centered services that are provided for an eligible client in order for the client to remain in an appropriate home environment.
- Developmental Disabilities Case Management
- Homemaker – assistance with environmental maintenance tasks provided in the adult individual's home.
- Adult Family Foster Care – provision of food, shelter, security, safety, guidance, and comfort on a twenty-four hour day basis, in the home of the caregiver.
- Respite Care – temporary relief to the individual's primary caregiver from the stresses and demands associated with daily care or emergencies.
- Adult Day Health – non-residential activities encompassing health and social services.
- Self-Directed Supports – the opportunity to direct a fixed amount of public resources in a flexible manner that is meaningful and helpful in achieving personally defined goals so the individual may remain in the family residence or in their own home.
- Personal Care Services – allow the individual to live as independently as possible while delaying or preventing the need for institutionalization.
- Home Health Care – intermittent nursing care provided in home to prevent institutionalization.
- Durable Medical Equipment – equipment designed to meet the medical needs of the individual.
- Non-emergency medical transportation – provides transportation to medical appointments and medical services.

SECTION C – ORGANIZATION AND ADMINISTRATION

C.1 Organizational Structure

Medical Services, (see Medical Services Organizational Chart below) the ND Medicaid agency, is a division of the Department of Human Services (see Department of Human Services Organizational Chart below) and will manage the demonstration grant. The Medical Services division is responsible for Medicaid eligibility regulations and policies; state plan service regulations, policies, and payment; payment for all waivered services; and policies and regulations for the provision of waivered services to the elderly and disabled. The ND MFP Grant Program Administrator is an employee of the Medical Services Division.

The Developmental Disabilities Division within the Department is responsible for policies and regulations for the provision of waivered services to the individuals who will transition from ICF/MR facilities including the Developmental Center.

Transition services for nursing facility residents will be coordinated between Medical Services and the four Centers for Independent Living (CIL) located throughout the state. In addition, to the transition services to be provided by the CILs, all individuals receiving HCB qualified services will be assigned a case manager from the county social services office, where the individual will be living, and who will authorize and monitor HCB services. The staff from the nursing facility will also be engaged with the assessment and discharge planning efforts.

Transition Coordination Services

Center for Independent Living-Transition Coordination: ND will contract with the four Centers for Independent Living serving ND to provide Transition Coordination Services. The four Centers include the following:

- **Dakota Center For Independent Living**
  3111 East Broadway Avenue
  Bismarck and Dickinson

- **Options Resource Center For Independent Living**
  318 3rd Street NW
  East Grand Forks, MN and Cavalier ND

- Freedom Re**source Center For Independent Living**
  2701 9th Avenue SW, Fargo and Jamestown

- **Independence, Inc. Center For Independent Living**
  300 3rd Avenue SW, Suite F, Minot

The Director of each Center will provide direct supervision to the Transition Coordinators working for their agency. The Center Directors will manage and supervise the day to day activities of all staff providing MFP related services and assure required documents, reports, and participant interactions occur as outlined in the contract negotiated with the Department of Human Services.

The MFP Program Administrator will evaluate the performance of each individual Center and the performance of the Transition Coordination service based on the scope of practice outlined in the contract.

Transition services for ICF/MR residents involve four entities with the Department (DHS) that all are accountable to the Executive Director of the Department:

- Medical Services Division –Medical Services have designated personnel that work directly with the Disability Services Division (DSD) to provide support in development and administration of MR/DD waiver and ICF/MR services.

- Disability Services Division (DSD) – Provides statewide policy and program development and support and oversight of MR/DD waiver and ICF/MR field operations. DSD administrators also participate in ongoing HCBS system planning and development with the Medical Services Division.

- Developmental Disabilities Case Management (DDCM) – Consists of DD case managers and Regional Developmental Disabilities Program administrators that supervise case managers within the regional Human Service Centers (HSCs) and manage and monitor the service system at the regional level.

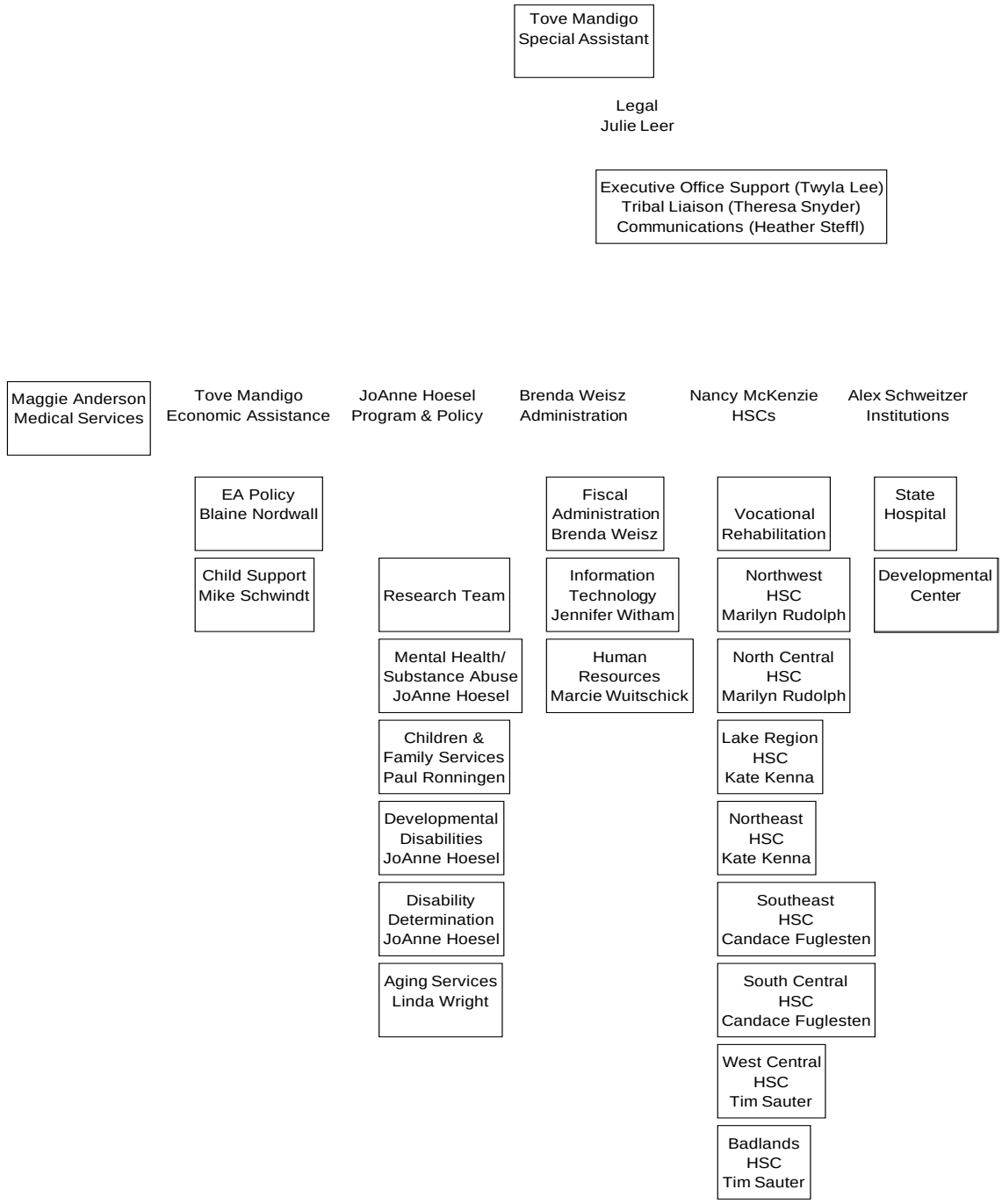
- North Dakota Developmental Center (NDDC) – Operates institutional ICF/MR services.

All individuals receiving services in community ICF/MRs are assigned a case manager from the regional Human Service Center to authorize and monitor services. This function includes ensuring individuals have choice between ICF/MR and waiver services and of the least restrictive service setting that will meet their needs. Responsibilities of DDCMs include referral and planning for transition of individuals from ICF/MR to MR-DD waiver/HCB services.

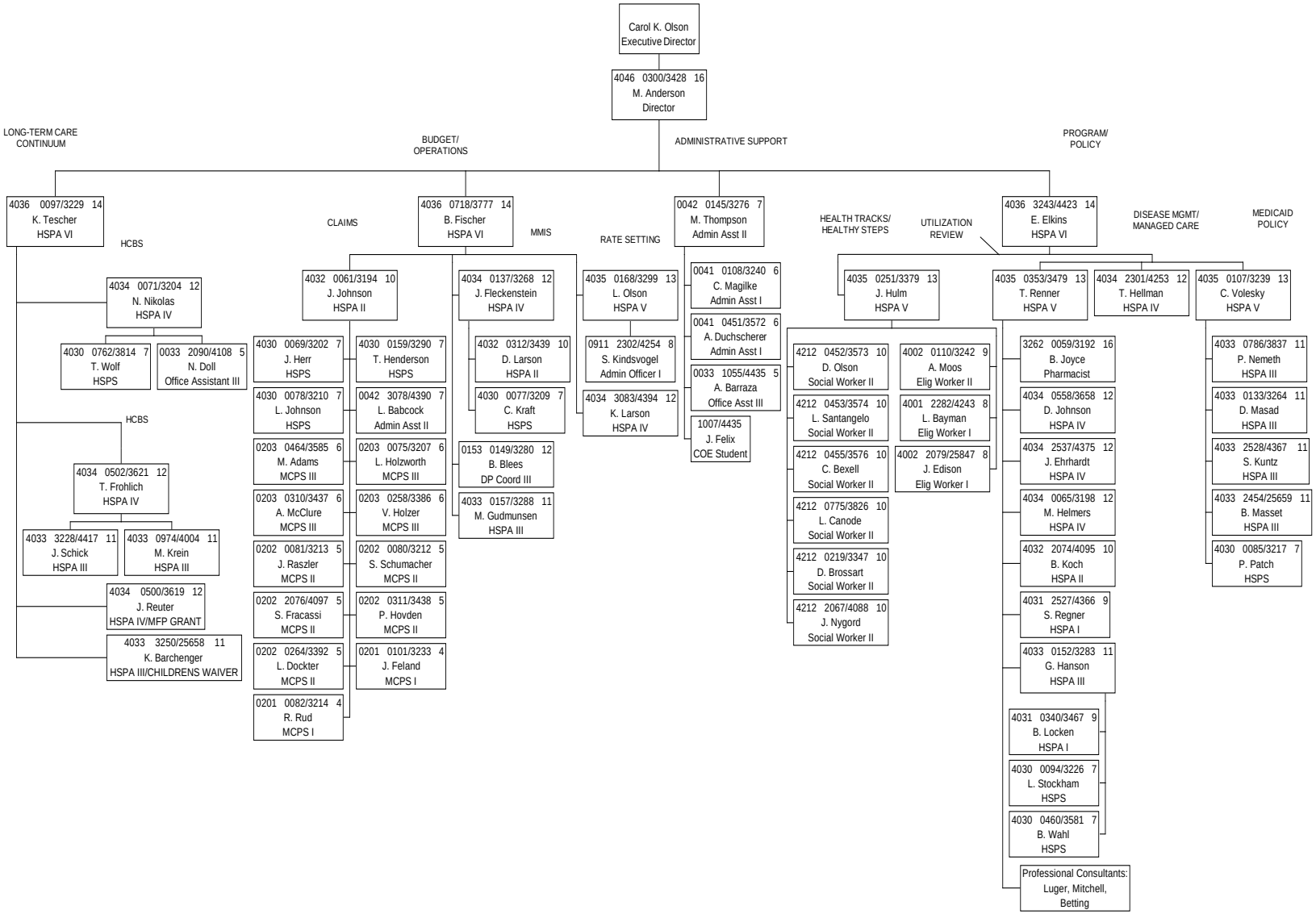
All NDDC residents are associated with a regional HSC representing their region of origin. A case manager is assigned to each individual at NDDC and is a member of that individual's Individual Support Plan team. This provides an ongoing and direct link for planning transition to the community service system.

DDCM communicates closely with the DSD in service planning and delivery. This includes at least monthly joint planning sessions between DSD, DDCM, and NDDC for evaluation and consideration for referral and transition to HCB services for NDDC residents. DDCM then works with designated NDDC personnel to facilitate referral to community HCB providers to effect transition to the community.

North Dakota Department of Human Services Organizational Chart



Division of Medical Services Organizational Chart



C. 2 Staffing Plan

Medical Services has identified Jake Reuter as the full-time Program Administrator for the Money Follows the Person Demonstration (See Attachment G for Resume).

The Developmental Center (DC) will have the following staff commitments to the demonstration:

- Keith G. Vavrovsky, Social Worker – ½ Full-Time Equivalent (FTE)
- Eight Unit Program Coordinators each at .05 FTE.

Regional Human Service Center staff will also be involved. This will include:

- DD Case Managers
- Regional Program Administrators

These professionals will assist individuals in the ICF/MR target population with referral, pre-placement, and follow-up services, it is estimated that each individual will require 83 hours of Case Management and six hours of assistance from the Regional Program administrators.

Developmental Disabilities Division

Robbin Hendrickson, Adult Service Program administrator, dedicated at .05 FTE. Robbin will provide oversight to the DD transition efforts and will assist staff at the DC and the HSCs.

Center for Independent Living-Transition Coordination

ND will contract with the four Centers for Independent Living serving ND to provide Transition Coordination Services. The four Centers include the following:

Dakota Center For Independent Living
3111 East Broadway Avenue
Bismarck and Dickinson

Options Resource Center For Independent Living
318 3rd Street NW
East Grand Forks, MN and Cavalier ND

Freedom Resource Center For Independent Living
2701 9th Avenue SW, Fargo and Jamestown

Independence, Inc. Center For Independent Living
300 3rd Avenue SW, Suite F, Minot

Each of the four Centers will provide a minimum of two staff members to function in the role of Transition Coordinator. Time allotted for this service will be based on number of referrals. The Coordinators will provide the supports needed to assist nursing facility consumers with their transition to the community. The Transition Coordinator will also assist consumers with application for supplemental support services available for one time transition related costs. Coordination services will also involve supporting consumer transitions for 365 days after their move from the nursing facility.

The Director of each of the four Centers will provide direct supervision to the transition coordination staff. This will include monitoring employee performance, report completion, compliance with privacy requirements, and conduct with consumers based on the scope of practice expectation outlined in the contact for services with the ND Department of Human Services.

The contract established by the Department of Human Services with each of the Centers outlines Transition Coordination service expectations. The MFP Program Administrator will evaluate the performance of the Transition Coordination services based on the scope of practice outlined in the contract.

Nursing Call Service Agency (Pending Informal Request for Proposal Process)
ND will contract with a nursing service agency to provide 24 hour phone backup services for MFP participants. The nursing agency will be providing staff 24 hours a day to manage these calls.

C. 3 Billing and Reimbursement

MFP participants that have been transitioned will be assigned a unique living arrangement code in the claims payment system (MMIS) which will allow for payment, reporting, and tracking of qualified HCB services. The code will also allow for collection of specific data on individuals transitioned ensuring individuals meet the eligibility criteria and will provide data to be used in the analysis of the success of the transition process. Specific data will include length of time institutionalized, length of time in community living, and costs of the transition plan.

Transition Coordination services will be a contracted service. Each of the four providers of this service will be required to submit monthly reimbursement requests on the required contract reimbursement form. Providers will track services provided in fifteen minute increments and will submit a request for payment of all services provided on a monthly basis. The provider will maintain an accurate accounting of services provided to individual MFP participants for program audit purposes. ND will randomly audit MFP service contracts and will initiate audits if questionable billing practice is identified.

Requests for Supplemental Services will be reviewed and authorized individually by the MFP Grant Program Administrator. A history of all payments for Supplemental Services will be maintained in the state's financial accounting system. The Grant Administrator will maintain individual files on all MFP participants for quality assurance review purposes.

Billing and payment to Qualified Service Providers is monitored routinely by the HCBS Staff of the Medical Services Division of the Department of Human Services to track billing accuracy and consistency with authorized services.

Medicaid Fraud and Abuse Unit Condensed Manual and Policies as they Relate to MFP Participants

In North Dakota the fraud unit is located within the Medicaid Program Agency. North Dakota requested a waiver and was granted the waiver do to a low volume of cases, making it not cost effective to have a separate unit from the Medicaid Agency.

Currently the unit has an administrator who is the chief auditor and investigator. The administrator is also the S/UR and TPL administrator. The Medicaid S/UR staff support the administrator in gathering Medicaid eligibility and medical payment information. There are one and one half staff members in the S/UR Unit.

The S/UR Unit in most cases conducts desk audits from referrals and exception review processing. As cases develop into potential recovery and/or criminal cases the auditor/investigator conducts a more thorough investigation, which may include an onsite announced or unannounced audit. Once the auditor/investigator has compiled a

criminal report or audit report (depending on the type of case) the merits of the case are discussed with the Medicaid Director to determine the course of action. The administrator makes recommendations to the Medicaid Director on what options may be pursued in each case.

If it is determined that the case should be referred to the Office of Inspector General (OIG) or the US Attorney's Office, the administrator prepares the report and evidence to be forwarded to the proper entity. The administrator then takes the role as technical advisor to that entity and may appear at a legal hearing as a witness to the findings.

If the matter is determined to be an administrative action to correct and recoup erroneous billings the administrator will start the procedures to notice the provider/recipient, inform the provider/recipient of the findings, the overpayment and the right of appeal. If the findings are not contested, the administrator will negotiate or dictate the terms for payment and/or other sanctions.

If the case is referred to the US Attorney or OIG for further development and processing, it is that entities responsibility to report any sanctions to the Office of Integrity for the national register. If the state takes action to sanction a provider the administrator will report the action to the OIG for the national register.
It is also noted that in some cases, the case may be referred to the Attorney General's Office or State's Attorney for prosecution in the state court. Most recipient cases are handled in this manner.

The North Dakota Medicaid Program also has full and part time professional staff that conducts peer reviews, authorizes out of state services based on necessity, and determine necessity in services being provided to Medicaid recipients by Medicaid Providers. The staff consists of a medical physician, nurses, dentist, full time pharmacist and optometrist. They are also available to assist in the desk audits and on site reviews where warranted.

The fraud unit when conducting audits and investigations adhere to all confidentiality rules and follow the due process for suspected individuals and entities.

SECTION D – EVALUATION

Evaluation is not a required component of the MFP Operational Protocol. North Dakota has opted not to include its own evaluation component in its MFP demonstration design. The State will utilize data collected by the national evaluator for the MFP evaluation as indicators of the project's effectiveness. We believe the national evaluator data will provide a clear picture of the status of each individual that has transitioned, thus allowing more time for the State to focus on the actual transition activities.

SECTION E – FINAL PROJECT BUDGET

Budget Narrative

During the four years of the demonstration project, we estimate 80 individuals will be transitioned from nursing facilities to the community, and 30 individual will be transitioned from ICF/MRs to the community.

Qualified Home and Community Based Services expenditures are budgeted at 240 hours per month of personal care services at $18.72 per hour; 8 home health visits at $80 per visit; and waivered services of $207 per month; inflated by 4% per year.

Transition Coordinator services provided before and after the transition of an individual are estimated to be a total of 60 hours at a cost of $60 per hour, increasing 4% per year. This service will be offered as both a demonstration and a supplemental services.

Qualified Home and Community Based Services expenditures for individual transitioned from ICF/MR facilities are estimated to be the average community adult ICF/MR daily cost plus residential and day support direct care staff enhancements for additional client needs to ensure the consumer's health and safety. Estimated costs are increased 4% per year.

Expenditures for one-time services such as deposits, home furnishings, vehicle modifications, and assistive devices, are estimated at $3,000 per individual transitioned from either a nursing facility or an ICF/MR facility.

Expenditures for 24-hour Backup Nursing Services are based on an average of two calls per month for each individual transitioned from either a nursing facility or an ICF/MR facility.

Expenditures for Federal Evaluation Supports are estimated at $300 per individual over the four years of the demonstration project.

The anticipated per capita expense of $92,168.46 for the grant period will consist of:

$86,071.86 – Qualified Home and Community Base Services (personal care services and other supportive services.

$ 2,679.73 – Demonstration Home and Community Based Services (Demonstration Transition Coordinator services and 24-hour backup services.

$ 3,416.87 – Supplemental Services (Supplemental Transition Coordinator services) and one-time start up costs.

See Attached Budget Forms and Documents